PROJECT CHECO SOUTHEAST ASIA REPORT

DRUG ABUSE IN SOUTHEAST ASIA (U)

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Contemporary
Historical
Examination of
Current
Operations

REPORT

DRUG ABUSE IN SOUTHEAST ASIA (U)

1 JANUARY 1975

CHECO/CORONA HARVEST DIVISION
OPERATIONS ANALYSIS OFFICE
HQ PACAF

Prepared by:
Major Richard B. Garver
Project CHECO 7th AF

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS PACIFIC AIR FORCES
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PROJECT CHECO REPORTS

The counterinsurgency and unconventional warfare environment of Southeast Asia has resulted in the employment of USAF airpower to meet a multitude of requirements. The varied applications of airpower have involved the full spectrum of USAF aerospace vehicles, support equipment, and manpower. As a result, there has been an accumulation of operational data and experiences that, as a priority, must be collected, documented, and analyzed as to current and future impact upon USAF policies, concepts, and doctrine.

Fortunately, the value of collecting and documenting our SEA experiences was recognized at an early date. In 1962, Hq USAF directed CINCPACAF to establish an activity that would be primarily responsive to Air Staff requirements and direction, and would provide timely and analytical studies of USAF combat operations in SEA.

Project CHECO, an acronym for Contemporary Historical Examination of Current Operations, was established to meet this Air Staff requirement. Managed by Hq PACAF, with elements at Hq 7AF and 7/13AF, Project CHECO provides a scholarly, "on-going" historical examination, documentation, and reporting on USAF policies, concepts, and doctrine in PACOM. This CHECO report is part of the overall documentation and examination which is being accomplished. It is an authentic source for an assessment of the effectiveness of USAF airpower in PACOM when used in proper context. The reader must view the study in relation to the events and circumstances at the time of its preparation--recognizing that it was prepared on a contemporary basis which restricted perspective and that the author's research was limited to records available within his local headquarters area.

Robert E. Hiller

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FOREWORD

(U) This CHECO Report addresses the problem of drug abuse in Southeast Asia (SEA), with emphasis on the drug situation in Thailand through the end of 1973. Many aspects of drug abuse in SEA have drastically changed since 1973, as a result of reduction in forces, discontinuance of urinalysis testing, and other variables. Nevertheless, this report not only serves as a record of drug abuse as it existed in 1973, but also provides a unique insight into the underlying causes of drug abuse -- and in this respect the value of the report is undiminished by the passage of time.

(U) Although the problem of drug abuse permeated the entire structure of American society, it did not surface as a major military problem until the latter part of 1970 when Congressional leaders expressed concern over the reported high degree of drug abuse among US military personnel in the Republic of Vietnam. As a result of this concern, the military organized a concerted effort to eliminate the problem. This effort and the results it produced are discussed in Chapter I. Subsequent chapters deal with the drug abuse problem and its treatment in Thailand following the removal of remaining US Armed Forces from Vietnam in accordance with the January 1973 cease-fire. Chapter II explores the etiology of drug abuse, emphasizing specific contributing factors to the SEA drug abuse problem. Chapter III is concerned with the five phase drug abuse program at work in Thailand and with clinical evaluation of its effectiveness. Chapter IV is a statement of conclusions and an analysis of those conclusions with emphasis upon implications for improvement in the current drug abuse program.

ABOUT THE AUTHOR

(U) It is perhaps significant to preface this report by noting that the author has a professional background which was conducive to a comprehensive treatment of this topic. Major Richard B. Garver is a psychologist holding doctorate degrees in both psychology and health, and has functioned as a clinician in that capacity in a medical setting during the time frame of this report. He has therefore experienced close clinical contact with many drug abusers and is qualified to relate this aspect of drug abuse in Southeast Asia. Major Garver is a regular Air Force officer, a rated parachutist, a senior weapons controller, and has served twice in Southeast Asia. Also, he was an instructor at the United States Air Force Academy. Additionally, Major Garver has authored a book and published a number of monographs in professional journals dealing with the psychological aspects of human performance.

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CHAPTER I

DRUG ABUSE IN VIETNAM: A SUMMARY

Introduction

(U) The primary objective of this summary is to describe the policies, procedures, and practices that were formulated and implemented by Seventh Air Force in dealing with the problem of drug abuse in Vietnam. The primary time frame for this section is January 1971 to January 1973 -- the period when the majority of the actions associated with the offensive against drug abuse were placed in effect. References are made to earlier events when they provide background information.

(U) To place the report in its proper perspective two factors must be considered. First, the problem of drug abuse within Seventh Air Force existed in a unique environment -- a combat zone where drugs were readily available and where the possibility of death was a constant reality. Second, all Air Force actions had to be conducted within the framework of the policies established by Military Assistance Command, Vietnam (MACV) Directive 190-4. This directive assigned responsibilities and furnished guidance to the United States Armed Forces in the Republic of Vietnam (RVN). The basic features of the program are best expressed by quoting paragraph 3 of the directive:

> Inclination and opportunity are two factors usually present when a drug offense is committed. To produce maximum results, a drug abuse suppression program must be directed toward both these factors. The program within the RVN must encompass many aspects; it must involve the eradication of drug sources, strengthening of customs and postal procedures, utilization of marihuana detection dogs, provisions for providing quality drug education effort, the implementation of drug abuse councils to manage and coordinate drug abuse suppression programs, integration of law enforcement

> agencies and the narcotics intelligence collected by these agencies, improved statistical reporting, diminishment of those social, psychological, and physical influences which may contribute to an individual's illegal use of drugs, and the inclusion of rehabilitative/ amnesty policies designed to assist the abuser in correcting his problem before his value as a productive human being is totally compromised.[1]

(U) Prior to 1971, Seventh Air Force's Drug Abuse Program was in its infancy. There were no historical antecedents to serve as models, therefore experience was gained by trial and error. Based upon guidelines contained in Air Force Regulation (AFR) 35-6,[2] Seventh Air Force published 7 AFR 35-9,[3] which established a Drug Abuse Prevention and Suppression Program that created base drug abuse prevention councils, established a central office within Seventh Air Force that coordinated all efforts in the field, and provided policy and guidance to the field units. The Inspector General was the original office of primary responsibility. However, the responsibility for the program was transferred to the Deputy Chief of Staff, Personnel in November 1970. The program was concerned with the identification and evaluation of drug abusers. This, in turn, led to a determination of counseling requirements, rehabilitation potential, and the need for trial by court-martial, disciplinary action, administrative separation, or other action. Each case was considered on an individual basis by the unit commander or a key official. Drug Abuse Prevention Councils were organized at Headquarters, Seventh Air Force and at each Seventh Air Force installation. The appropriate commander appointed the base councils which convened a minimum of once each month and were comprised of representatives of the chaplain, the judge advocate, the information office, base personnel, the surgeon, the chief of security police, and

the Office of Special Investigations (OSI). Special emphasis was placed on including the younger officers, noncommissioned officers, and airmen who were knowledgeable of drug abuse problems, as either members or advisors to the councils. The regulation also directed a continuing information and education program within all units and established reporting procedures. Essentially, the program concentrated on education for prevention, discipline, and rehabilitation.

(U) Based upon the premise established by 7 AFR 35-9, the Seventh Air Force Drug Abuse Program experienced a gradual and steady increase in activity. However, the tempo of activity was relatively slow when compared with the flurry of actions that followed the initiation of urinalysis testing in June 1971. With the advent of project "Golden Flow" the entire drug abuse program was expanded and gained momentum.

Drug Education Programs

(U) MACV policy on drug education was to develop a program that was factual, to the point, and interesting.[4] The specific objectives were:

- to convince the nonuser not to experiment with drugs;
- to convince the experimenter/casual user not to continue his abuse;
- to convince the addict to seek out professional assistance to rid him of his problem; and
- to convince the supplier to discontinue his involvement in drug abuse.

(U) Seventh Air Force's Drug Education Program was an integral part of the MACV Program and included a wide variety of approaches and techniques. Early efforts concentrated primarily on workshops, seminars, and

briefings.[5] During 25 through 27 January 1971, a Drug Abuse Workshop was held at Tan Son Nhut Airfield, Headquarters, Seventh Air Force, and all Seventh Air Force installations were represented. The attendees were given extensive information on the pharmacological, social, cultural, and psychological aspects of drugs and their abuse. They were also provided with a background on the legal aspects of drug abuse as it related to military policies and regulations. The basic purpose of the workshop was to train a cadre of responsible and motivated personnel who then returned to their respective installations and established base-level drug education and control programs within the framework of the program established under 7 AFR 35-9. During 17-19 February 1971, a medical seminar on drug abuse was conducted at Cam Ranh Bay by the Surgeon's Office. It provided the Command's doctors with the latest information on the medical aspects of drugs and their abuse. A follow-on seminar was conducted on 6 April 1971 and similar seminars continued until the withdrawal program was effected.

(U) Under the direction of the Seventh Air Force Chaplain, March 28, 1971, was declared "Drug Sunday" and a standardized nondenominational sermon on drug abuse was given at all Seventh Air Force installations to all faiths. The sermon concentrated on the various ways in which people could help each other in overcoming the drug problem.

(U) During May 1971, the Seventh Air Force libraries sponsored a Drug Abuse Education Month and featured special displays on drug abuse literature.

(U) Other Seventh Air Force educational efforts included the distribution of OSI handouts which contained information that assisted supervisors

in identifying drugs, drug paraphernalia, and likely hiding places. Also included was a bilingual letter which was signed by the Commander, Seventh Air Force, and which solicited the support of all Vietnamese employees in combating the drug problem. It also made it clear that the selling of drugs would not be tolerated and would result in the immediate termination of employment.

(U) The base-level drug abuse prevention and suppression programs were provided with an abundant supply of charts, posters, books, pamphlets, and other written material whose topics were related to all facets of the drug abuse problem. Many of the publications were handed out during newcomers' briefings which provided information on recognition of drugs that were readily available in RVN and which covered the physical, psychological, and legal consequences of drug use. The briefings concentrated on being factual and avoided the use of scare tactics. The majority of the drug education activities were centrally managed or monitored by the base drug abuse and prevention council.

(U) In addition to the specific Seventh Air Force efforts,[6] Armed Forces Vietnam Network (AFVN) disseminated locally produced drug abuse information over its radio and television facilities. Beginning in June 1971, AFVN averaged from 16 to 18 spots on AM radio, 4 spots on FM radio, and 3 spots on television per day. The radio spots averaged from one-half to one and a half minutes each while the television spots usually ran about one and a half minutes. The AFVN material was supplemented with programs furnished by the Armed Forces Radio and Television Service (AFRTS).

(U) The MACV newspaper, The Observer, Seventh Air Force's Seventh Air Force News, and the Pacific Stars and Stripes carried numerous articles

on drug identification, drug rehabilitation, drug exemption programs, urinalysis testing, etc.

(U) One of the most effective and well accepted aspects of the drug education program was the MACV Drug Education Field Team (DEFT).[7] Each DEFT was comprised of five men -- two young, highly qualified US military personnel, one Vietnamese, and two civilian ex-drug addicts who were in Vietnam on a loan basis from the National Council for the Prevention of Drug Abuse. The civilians were thoroughly integrated into the effort. They worked and lived with the military members, providing additional credibility and establishing rapport with the audience. Five teams traveled throughout the RVN and visited Seventh Air Force bases, where they were well received. The DEFTs worked with small groups of 10 to 25 individuals and let the facts speak for themselves. They provided sufficient time for questions and answers as well as participation in lengthy discussions. Presentations were made to incoming personnel, officers and senior noncommissioned officers, young airmen in the grades E-1 through E-5, Vietnamese supervisors, and to Vietnamese laborers.

Identification/Detection of Drug Abusers

(U) The identification/detection of drug abusers in Seventh Air Force centered around two major programs -- law enforcement and urinalysis testing.

(U) Apprehending or investigating drug abuse suspects through conventional security police law enforcement and OSI investigative activities were the primary means of identifying drug abusers during the period 1965 through 1970. Records indicate that since 1965, when the first major troop

deployments were made to the RVN, the degree with which US Armed Forces personnel were involved in drugs underwent a steady increase.[8] During 1965, 47 military personnel were apprehended or investigated for abusing drugs. This figure increased to 562 in 1966, 1,390 in 1967, 3,460 in 1968, and 8,466 in 1969. This statistical trend must be accepted with caution as the in-country strength of US Armed Forces personnel was also increased between 1965 and 1969. Instead of yearly totals over an unknown base, a more accurate indicator of an increase in drug abuse would be a trend expressed in terms of rate per thousand. Table 1, Drug Offenses Within Seventh Air Force, August 1969 - 25 September 1970, reflects the monthly rates in these terms and comparatively is representative of the time period and trend. Although the rates are expressed separately for narcotics (any opiates or cocaine), marijuana (the intoxicating products of cannabis sativa), and dangerous drugs (those non-narcotic substances which the Attorney General or his designee, after investigation, has found to have a potential for abuse because of their depressant or stimulant effect on the central nervous system or their hallucinogenic effect), the trends lend support to the previous figures which reflected an overall increase in drug abusers during the period 1965 to 1970.

(U) Urinalysis testing was started in Seventh Air Force on 21 June 1971.[9] It consisted of two screening tests (Free Radical Assay Technique or FRAT and Thin Layer Chromotography or TLC) and one confirming test (Gas Liquid Chromotography or GLC).[10] The FRAT detected the presence of opiates by measuring the exchange of electrons between the opiate in the sample and a chemical solution with which it was mixed. The TLC test was used for two purposes. By using an untreated urine sample it could detect

TABLE 1

DRUG OFFENSE RATES WITHIN SEVENTH AIR FORCE
Aug 1969 - Sep 1970

Month	7AF Strength	Narcotics		Marijuana		Dangerous Drugs	
		Number of Persons	Rate per Thousand	Number of Persons	Rate per Thousand	Number of Persons	Rate per Thousand
Aug 69	60,000	0	.00	6	.10	0	.00
Sep 69	56,000	0	.00	14	.25	0	.00
Oct 69	55,555	0	.00	25	.45	0	.00
Nov 69	55,000	0	.00	22	.40	0	.00
Dec 69	58,800	0	.00	20	.34	0	.00
Jan 70	57,384	0	.00	12	.21	1	.02
Feb 70	55,481	4	.07	11	.20	0	.00
Mar 70	53,853	0	.00	24	.45	0	.00
Apr 70	52,199	4	.08	16	.31	9	.17
May 70	51,465	3	.06	18	.35	8	.16
Jun 70	50,469	1	.02	27	.54	4	.08
Jul 70	49,607	2	.04	19	.38	3	.06
Aug 70	47,984	8	.16	33	.68	7	.14
Sep 70	46,958	4	.08	22	.46	3	.06

SOURCE: Data provided by Drug Abuse Control Officer, Udorn Royal Thai Air Force Base (RTAFB), Nov 73.

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amphetamines and barbiturates, while by using a hydrolyzed urine sample it could detect opiates. The GLC was used to confirm the presence of opiates in samples that had tested positive to either the FRAT or TLC test. All three tests were used in conjunction with a "Logic Table" (see Table 2) which then led to a determination on the disposition of personnel with positive results of opiates.

(U) Initially, urine samples were collected from USAF personnel who were scheduled to depart RVN because of a permanent change of station or because they were classified as program workers (personnel assigned to urine collection points, detoxification centers, etc.).[11] During the early stages of the testing program, the specific procedures were constantly evaluated and improved. Urine samples were collected at Bien Hoa, Binh Thuy, Cam Ranh Bay, Da Nang, Nha Trang, Phan Rang, Phu Cat, Pleiku, and Tan Son Nhut Air Bases, and were assayed at US Army laboratories at these locations.[12] The Army testing facilities notified the appropriate Air Force medical liaison teams of the results, and they, in turn, notified by immediate message the USAF medical units that initially collected the samples as well as the installation Director of Personnel and Drug Abuse Officer. During August, September, and October 1971, the urinalysis testing program was expanded to include (1) personnel departing RVN after 30 or more days of in-country temporary duty, (2) personnel going on 14 days of ordinary leave to any destination, (3) personnel requesting approval of an overseas tour extension, (4) personnel departing on Rest and Recuperation (R&R), (5) personnel applying for reenlistment, (6) personnel departing on 7 and 7 (combination of R&R and leave), (7) suspected users of drugs, (8) unit testing, (9) random samplings, (10) limited privileged

TABLE 2

DISPOSITION TABLE

FRAT	TLC	GLC USED	GLC RESULTS	DISPOSITION
Neg	Neg	No	N/A	Normal
Neg	Pos	Yes	Pos	Detoxification
Neg	Pos	Yes	Neg	Observation
Pos	Neg	Yes	Pos	Detoxification
Pos	Neg	Yes	Neg	Observation
Pos	Pos	Yes	Pos	Detoxification
Pos	Pos	Yes	Neg	Observation
Neg	Not Used	Yes	Pos	Detoxification

SOURCE: Data provided by Drug Abuse Control Officer, Udorn RTAFB, Nov 73.

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communication program (LPCP) participants, (11) AFR 39-12 separatees, and (12) others as deemed necessary.[13]

(U) Table 3 shows the percentage of positives, by test category, for the periods June through September 1971 and October through December 1971. During the first period, personnel scheduled for separations under the provisions of AFR 39-12 produced the highest percentage of positives -- 20.68 percent. Suspected users had the second highest percentage with 17.35 percent, while LPCP participants had a rate of 9.34 percent. During the last quarter of 1971, the LPCP category had the highest rate, 14.45 percent, followed by the suspected users category with 8.89 percent, and the AFM 39-12 category with 4.68 percent. The overall percent of positives dropped from 0.97 percent during the first period to 0.50 percent during the second period. This downward trend is evident across all categories except for LPCP where the increase was accounted for by the conducting of follow-up testing in the base-level rehabilitation programs. In summary, the urinalysis testing results indicated a definite drop in the degree of drug involvement during the period 21 June to 31 December 1971. That general trend continued until US troop withdrawal in January-February 1973.

(U) Table 4 reflects the percentages of positives by base. During the period June through September 1971, Cam Ranh Bay and Phan Rang led all Seventh Air Force installations with 1.45 percent and 1.40 percent, respectively. Phu Cat followed with 0.94 percent. During October through December 1971, Phu Cat had the highest rate, 0.84 percent, followed by Da Nang with 0.73 percent. The rates for all bases, with the exception of Pleiku, dropped during the last quarter of 1971. No specific reasons

TABLE 3

URINALYSIS TESTING RESULTS

Reason For Test	Jun - Sep 1971			Oct - Dec 1971		
	Nr. Tested	Nr. Positive	Percent	Nr. Tested	Nr. Positive	Percent
DEROS*	15,075	67	0.44	10,938	29	.26
LPCP	214	20	9.34	165	24	14.54
AFM 39-12	87	18	20.68	64	3	4.68
Leave and R&R	2,414	7	0.28	7,654	2	0.02
Program Workers	2,044	6	0.29	1,893	2	0.10
Suspected Users	438	76	17.35	416	37	8.89
Random Samples	1,312	29	2.21	4,545	31	0.68
Tour Extensions	750	2	0.26	316	0	0.00
Reenlistments	171	0	0.00	860	0	0.00
Unit Tests	**			2,858	19	0.66
Other	1,268	6	0.47	481	5	1.03
Total	23,773	231	0.97	30,190	152	0.50

* Date Eligible (Effective) for Return From Overseas.
**Testing Not Conducted.

SOURCE: Data provided by Drug Abuse Control Officer, Udorn RTAFB, Nov 73.

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TABLE 4

POSITIVES BY BASE

Base	Jun - Sep 1971			Oct - Dec 1971		
	Nr. Tested	Nr. Positive	Percent	Nr. Tested	Nr. Positive	Percent
Bien Hoa	2,254	16	0.66	2,457	5	0.20
Cam Ranh Bay	4,532	66	1.45	6,019	28	0.46
Da Nang	3,855	31	0.80	6,934	51	0.73
Phu Cat	1,695	16	0.94	2,380	20	0.84
Phan Rang	2,913	41	1.40	3,520	20	0.56
Pleiku	441	1	0.20	658	3	0.45
Tan Son Nhut	8,083	60	0.74	8,222	25	0.30
Total	23,773	231	0.97	30,190	152	0.50

SOURCE: Data provided by Drug Abuse Control Officer, Udorn RTAFB, Nov 73.

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could be given for Pleiku's increase.

(U) Generally, the efficiency and effectiveness of identification and detection procedures improved steadily throughout the continuation of their usage and were instrumental in the overall contribution to the drug abuse program in RVN.

Intelligence and Enforcement

(U) Intelligence played a critical role in the MACV campaign against drug abuse. In the fall of 1970, MACV initiated a special intelligence request to all units seeking information concerning enemy involvement with the production and distribution of drugs. However, no conclusive data was ever collected substantiating enemy involvement with drug trafficking on a strategic basis. In several isolated reports of sale or transport of marijuana or heroin, the enemy proved to be only motivated by individual profit.

(U) Enforcement became a primary concern to every commander. The MACV description of enforcement included suppression of the use and possession of illegal drugs by servicemen, suppression of drug availability through detection and apprehension of peddlers and low level suppliers, and finally, the interdiction of the flow of drugs at all levels of the trafficking network.

(U) The MACV Provost Marshal's office was the principal staff agency responsible for supporting the commanders by working in conjunction with other law enforcement agencies such as the Bureau of Narcotics and Dangerous Drugs, the Joint Narcotics Investigation Detachment, and the Joint Customs Group. These agencies integrated all Vietnamese and US

efforts in suppression of drug sources and traffickers.

(U) Early enforcement was ineffective primarily due to public and official indifference. While drug abuse was publicly denounced, the average Vietnamese citizen remained quite ignorant of the seriousness of the drug threat. Others continued to engage in drug trafficking for its financial benefits.

(U) Nevertheless, police enforcement showed marked gains in improving public and official knowledge of the nature of drugs through training, pamphlets, posters, radio, and television. Marijuana and heroin seizures showed increasing effectiveness and a definite positive trend.

(U) Another definite indication of increasing Vietnamese motivation to control drug abuse was apparent in Saigon. Several areas known to contain drug trafficking were placed off limits to US personnel. Many local merchants developed self-help campaigns which successfully cleaned up their areas. Also, increasing concern for drug contamination of the Vietnamese children precipitated more active involvement in drug suppression.

Treatment and Rehabilitation

(U) MACV[14] viewed the treatment program, involving both detoxification and rehabilitation, as a command responsibility. The MACV Command Surgeon and surgeons at all levels provided medical guidance and support to the commanders. There were 13 Army rehabilitation centers available to servicemen in Vietnam, each staffed by at least two officers and 26 counselors and rehabilitation technicians. The Air Force treatment program utilized existing medical facilities, while the Navy sent drug abusers

to Miramar, California for rehabilitation.

(U) The treatment program was available to all who needed help, whether the individual was apprehended, was identified through testing, or voluntarily requested amnesty. Initiated in 1969, the Army's exemption (amnesty) program was also known as exemption by the Navy and Marine Corps, and as the "Limited Privileged Communication Program" by the Air Force, all of which had essentially the same connotation.

(U) Exemption permitted a man to voluntarily obtain freedom from punishment for his past use of drugs, provided there were no drugs in his possession and he was not involved in the purchase or sale of drugs. This provided the user an opportunity to obtain full medical and counselling assistance in separating himself from the drug environment. Simultaneously, he avoided punishment for previous drug usage.

(U) It was clearly publicized that exemption was for prior drug usage and that it was not an escape for the user or the individual who committed other crimes. Further, exemption did not preclude standard administrative actions such as removal of security clearance, transfer to less sensitive duties, or even removal from a promotion list.

(U) Following rehabilitation the individual was normally returned to his unit for follow-up observation and treatment. The success of this program depended heavily on command interest, constant coordination with professional rehabilitation personnel, and the attitudes of unit personnel.

(U) It should be emphasized that exemption was not a precondition for rehabilitation. Rehabilitation was available for all who required help. MACV recognized that both the environment and the time available for treatment in Vietnam influenced greatly the effectiveness of their

rehabilitation program for the deeply involved user. Those individuals required further intensive rehabilitation efforts upon their return to the United States. This further rehabilitation and treatment of the serviceman was to take place at an appropriate military installation. If the individual was returning for discharge from the service, he had the opportunity to seek further treatment at the Veterans Administration hospital with this capability which was nearest to his home.

(U) In summary, MACV explored every conceivable approach available to them during this time period to combat the drug problem. Based on their experiences and lessons learned in Vietnam, the drug abuse control personnel in Thailand continued to expand and improve upon these programs of education, detection, suppression, and treatment. These efforts and the resulting programs in Thailand will be discussed in detail in Chapter Three.

(U) Drug abuse has been recognized professionally as a manifestation of deeper psychological problems. The next chapter discusses the etiology of drug abuse with particular emphasis on contributing factors that produced drug abuse in SEA.

CHAPTER II

ETIOLOGY OF DRUG ABUSE IN SEA*

General Background and Underlying Psychology

(U) Drug abuse is not a recent phenomenon. Drugs have existed for man since the days of ancient Egypt. A number of reports indicate that the Chinese used marijauna fifty centuries ago to treat various diseases. Pain killers have supported men in battle since the early days of civilization. So drug use and drug abuse are a part of our human history.

(U) The drug dependent individual is basically one who finds the effects of drugs to be a solution of his problems. The drug becomes so essential to the patient that he cannot face reality without it. In drug dependency, particularly in the early stages, there is no damage to the nervous system. When damage does occur, the condition is classified as a brain syndrome rather than as drug dependency.

(U) The World Health Organization Committee on Drugs[15] defines drug dependency in the following way:

> A state of periodic or chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (2) a tendency to increase the dose; (3) a psychic (psychological) and sometimes, a physical dependency on the affects of the drug.

(U) It is recognized that many drug abusers are experimenters or users, not addicts. The primary criteria for differentiation between these categories are intent, circumstances of use, and the user's psychological

* See Glossary of Psychological Terms, p. 97, for definitions of many of the terms used in this chapter.

make up. The degree of involvement is very often a matter of exposure time and the amount of psychopathology present.

(U) Relatively little is known about the personality type and constitutional make-up of persons most likely to become addicted to drugs. Such factors as the need for attention, latent homosexuality, narcissism, passive inadequacy, aggression, and similar characteristics have been suggested as being important in the dynamics of the addicts. These factors, however, are also found in alcohol addiction. While it is impossible to suggest a single personality factor for drug addiction, many addicts appear to be noncompetitive and somewhat passive individuals who use drugs to obtain relief from their underlying anxieties.

(U) In a recent review of current psychiatric treatment techniques in drug abuse and their effectiveness,[16] several casual factors were discussed. Drug addiction, according to the Diagnostic and Statistics Manual of the American Psychiatric Association,[17] has been classified as a sociopathic personality disturbance; in psychoanalytical theory it has been classified with other impulsive disorders. Here the addict is attempting to gain security, assurances of self assertion which are essential to his very existence. Addicts, therefore, are many times considered to be distinctively impulsive. The word addict, per se, connotes an urgency of the need and the final insufficiency of all acts to satisfy it. Kleptomanics often get into a vicious circle because stealing gradually becomes insufficient to give relief. They must steal more and more. These persons might be called theft addicts. Certain other individuals are violently compelled to devour whatever food is in reach at the moment; they are food addicts.[18]

(U) Drug addicts differ in some respects from these other addicts without drugs. There is a critical difference which forces the drug addict to become more compelled; this difference is the chemical effect of the drug. The usual effects of drugs used by addicts are either sedative or stimulating. There are many occasions in life in which the longing for these effects may be very legitimate. If a person in such a situation uses drugs and ceases to use them when he is out of the situation, he is not called an addict. A person suffering from pain who receives an injection of morphine has received necessary protection. Similarly, the euphoric drugs are protection against painful mental states, for example against depression, and are indeed often very effective. Providing the use of drugs remains solely a protective measure; there is no addiction. An addict is a person to whom the effect of the drug has a subtle imperative significance. Initially, the patient may have sought nothing but consolation. When he comes to see, or attempts to use, the effect of drugs for the satisfaction of another inner need, the person becomes dependent on this effect, and this dependency eventually becomes so overwhelming as to negate all other interests. Thus, the problem of addiction reduces itself to the question of the nature of the specific gratifications that a person of this type will try to derive from the chemically induced sedation or stimulation, as well as the condition that determines the origins of the wish for such gratifications. In other words, addicts are persons who have a disposition to react to the effects of alcohol, morphine, or other drugs in a specific way. They use these effects to satisfy basic needs such as oral, sexual, security, and the need for maintenance of self-esteem, simultaneously. Thus the origin and the nature of the

addiction are not determined by the chemical effect of the drug, but by the psychological structure of the patient. The premorbid personality is therefore the decisive factor. These persons become drug addicts because the effects of the drug have a special significance for them. It means the fulfillment, or at least the hope of fulfillment, of a deep and primitive desire more urgent for them than are sexual or other distinctive longings by other individuals.[19]

(U) Addicts react to certain situations that create the need for sedation or stimulation differently from others. They are intolerant of tension; they cannot endure pain, frustrations, or situations requiring patience. They seize any opportunity for escape more readily, and may experience the effect of the drug as seeming much more gratifying than the original situation that had been interrupted by the precipitating pain or frustration. After the elation, pain or frustration becomes all the more unbearable, inducing a heightened use of the drug, all other drives become more and more replaced by the pharmacological longing. Interests in reality gradually disappear except those related to procuring the drug. In the end, all of reality may come to reside in the drug. Occasionally, the pleasure is secured through the skin and it is a passive receptive one. More important than any erogenous pleasure in drug elation, however, is the extraordinary elation in self-esteem. During the drug elation, erotic and narcissistic satisfactions visibly coincide again.[20]

(U) The addict experiences the relation between drug addiction and the manic depressive states. In their final stages, drug addicts live in meaningless alternating states of elation and morning-after depression,

which in the last analysis corresponds to the origin of hunger and satiation in the mentally undifferentiated infant. The morning-after depression becomes more and more prevalent in the later complications of addiction. The decisive complications in the psychology of addiction are represented by the increasing inefficiency of the elation achieved, physiological and psychological conditions still to be investigated, the gate to this efficiency, or even the appearance of elation. The patient must resort to larger doses at shorter intervals. Lack of effect increases the longing. The tension increases with the longing and if not gratified, becomes more unbearable. Now the drug is used less for the purpose of obtaining pleasure, but rather as an inadequate protection against an unbearable tension related to hunger and guilt feelings. The decrease of the effect of the drug certainly has a physiological root, but there are also psychological ones. If, after drug elation, the same misery that initiated the use of the drug must be faced again, it necessitates more frequent and more intense escape.[21]

(U) It has also been mentioned that actions created out of the purpose of protection against supposed dangers may in fact become dangers themselves, and thus a vicious circle is created. This is what happens to the addict also. As the addict becomes aware of his progressive mental disintegration, he certainly perceives it as a danger, but he has no other means of meeting this danger except by increasing the amount of the drug. In drug addiction, the idea that the protective measure may be dangerous is, for physiological reasons, a very real one. The patient becomes aware of this and gets into the unresolvable vicious circle. The manic depressive circle between elation and morning-after depression

becomes more and more regular, elation shorter and shorter and eventually disappearing, with depression becoming more permanent.[22]

(U) Psychotic disturbances do not occur more frequently in addicts. In current nosology most addicts fall into four main categories of personality disturbances: (1) Personality Pattern Disturbances or the pathological personality, such as the inadequate personality; (2) Personality Trait Disturbance or the immature personality such as the passive dependent personality; (3) Sociopathic Personality Disturbance of the anti-social or dyssocial variety; (4) all varieties of Psychoneurosis.[23]

(U) The psychiatric diagnoses have not appeared to be helpful in predicting the course of treatment for an addict. Borderline psychotics often overcome addiction and remain drug-free, and mild character disorders often remain intransigent addictives. We must conclude that addiction may exist in individuals with almost any psychic organization, and that they may overcome the illness without necessarily going through any obvious change in their personality.[24]

(U) There is undoubtedly a psychological factor which determines an individual's reaction to drugs, and more specifically, why he chooses the drug he does. Work with placebos indicates that the person who will get consistent relief of pain from placebos is also apt to favor opiates over other drugs.[25]

(U) Characteristic of the addict's psychology is his ambivalence regarding drugs. This is reflected in his statements and in his jargon, in which he refers to drugs as "junk" or "crap." One observes a flattened affect in some addicts. This state is desired by the addict and is given the word "cool." In his innermost self, his idealized image is to

be a person who is quiet, tranquil, untroubled, and contemplative. Narcotics facilitate just such a state by virtue of their action in reducing aggression. So strong is the action of narcotics on aggression, that vicious criminal tendencies have been known to be reduced or eliminated after addiction.[26]

(U) The continued use of drugs solidifies behavior, which includes a passive withdrawal from the main stream of life. The addict's symptoms become like a religion to the other addicts, and he moves in a circle inhabited by other such persons. They not only accept in each other the anti-social behavior into which they are forced, but develop their own language for communication. Although they feel partially rejected by the nonaddict world, they, in turn, exclude nonaddicts. Though these concommitants to addiction may prove decisive in the treatment of addicts, they are not necessarily representative of the basic dynamics behind addiction.[27]

(U) In summary then, we may say that the complicated psychodynamic picture of the addict must include: (1) a possible premorbid personality problem; (2) normal strivings on a sexual and aggressive level; (3) overwhelming anxiety when it comes to satisfying these strivings by life's ordinary methods; (4) the knowledge of a drug which is pharmacologically specific for satisfying these strivings; (5) the creation in him of a new need by the use of narcotics; and, (6) the all important secondary reaction and gains from the continued use of narcotics.[28]

Contributing Factors Specific to Abuse in SEA

(U) Military men in SEA seem to compose a subculture of their own. They exhibit a behavioral posture which is much different than that of

their counterparts in the US, and which even differs from their own behavioral posture in the US. This does not mean that their personalities undergo radical restructuring, but simply that they are presented with a composite of significantly different environmental stimuli which elicit new responses. This writer has interviewed and clinically treated a considerable number of drug abusers in SEA and has noted a substantial behavioral modification from stateside duty to SEA duty as indicated by their own self report, observed behavior, and military record of performance. Four specific contributing factors to drug abuse in SEA were observed with noticeable consistency, although no controlled statistical treatment such as frequency distribution was available. These factors were: (1) threat or boredom, (2) separation from a familiar environment, (3) availability and cost, and (4) peer group pressure.

(U) Threat or Boredom. Threat, one of the key psychological components of stress, may be defined as anticipation of a specific harm -- that is, the undesirable result of an individual's physiological or psychological needs. The greater the anticipated harm, the greater the threat, and the more intense will be consequent emotion and the efforts to cope or adjust.

(U) Grinker and Spiegel[29] made an analysis of threat as it related to combat stress in aircrews and concluded that learning is the assumed basis of threat. They describe how the aircrews learn to anticipate harm from flak bursts after seeing the damage it can do.

(U) The dangers of combat are also discovered partially through the disasters that occur to comrades:

> The men suffer not only from the sense of bereavement but from having seen the anguish of bloody, painful death. They cannot look away when the ship flying on their wing receives a direct flak hit and bursts into flames. The sight of their tentmates bailing out with burning parachutes, or exploded out of a disintegrated ship, becomes stamped on their memory. The empty beds in the tent at night reflect this memory which does not disappear with the sending home of their buddies' clothes and personal effects. The grief persists and, though it is dulled by time, new losses may be added to it. In addition, the loss of friends stimulates increased anxiety. What happened to his buddy may well happen to himself since they are so much alike.

(U) Threat was often present in Vietnam and certainly triggered many of the responses of the drug abuser there.

(U) With the ceasefire, when Thailand became the new environment for the serviceman in SEA, bordeom rather than threat, was the enemy. Off-base leisure time became more plentiful, and for many individuals, experimentation with drugs was the method chosen to combat apathy and boredom and to create some excitement or challenge. The young drug abuser now failing to derive a feeling of self importance as a part of the mission, found no glamour in the daily mundane tasks around the barracks or the base. But drugs did provide the glamour, if only superficially, and the excitement of glamour was only enhanced by establishment disapproval.

(U) Separation from Familiar Environment. Separation from a familiar environment is not new to the serviceman, but in the presence of other contributing factors, this one particular factor becomes extremely important. It undermines the inadequate personality, the individual with low self-esteem, poor self-concept, and on many occasions causes his feelings of insecurity to become unbearable. In fact, the separation from family and friends is sufficient stimulus to cause any personality disturbance to elicit acting-out behavior typical of that

particular personality disturbance. This individual then seeks escape and relief with drugs. We have previously discussed the underlying psychology concerned with this phenomenon, and therefore it will suffice to simply indicate here that this separation from a familiar environment is the precipitating factor which triggers the entire process. The separation itself creates sufficient anxiety within the individual to cause him to seek relief. But when the family separation also includes unresolved problems at home, the individual feels a pathetic sense of helplessness, and he is severely frustrated and threatened by this situation. Without assistance or direction the individual is unable to cope and experiences a situational reaction with more anxiety accompanying it. Again he seeks solace in the artificial euphoric state induced by drugs.

(U) Availability and Cost. This is one of the most critical and significant factors involved in drug abuse in Southeast Asia. The drug abuser has absolutely no difficulty in obtaining his drug of choice from the nearest samlar* driver in the local town. And although the government of Thailand has made great strides, as has the Republic of Vietnam, in controlling the trafficking of drugs as well as the sale of drugs, the availability of all drugs has been high. There has been one redeeming feature to this, and that is the lack of usual accompanying crime associated with acquiring drugs. There is no reason to commit crime to acquire money to purchase drugs in Southeast Asia, because the cost of these drugs is only a fraction of the cost in the United States. The average serviceman, regardless of rank, had no difficulty in financing his habit. Additionally, the quality and potency of the available drugs was greatly

* A three wheeled, man-powered conveyance.

increased by the purity of the product found in Southeast Asia. Therefore, less of the drug was required to produce the same desired effect. In summary, the plentiful availability and low cost of drugs greatly facilitated the abuse of all drugs in Southeast Asia.

(U) Peer Group Pressure. Among young adults (ages 17-29) use of drugs has been the "in thing," and in a forced environment such as the environment in Southeast Asia peer group pressure in this age group was important. Acceptance in the group was vital to the individual's self-esteem and other critical social needs. This particular contributing factor is not entirely specific to drug abuse in Southeast Asia. However, when combined with other pressures, it becomes another critical factor. The environment of Southeast Asia produced a feeling of aloneness which was only bearable when acceptance was available in one's own peer group. So if acceptance by the individual's peer group was contingent upon or was enhanced by the use of drugs, the individual was highly motivated to participate in drug abuse if only to gratify his original need of social acceptance. Of course, this particular type of pressure again most critically and severely affected the individuals with underlying psychological problems, such as deep personality disturbances. These individuals did not have a high threshold to stress and were very vulnerable to this intense peer group pressure.

(U) Summarily, it is extremely important to note that even as these specific contributing factors to drug abuse in SEA are interdependent, they are also dependent upon the basic underlying psychological factors which were discussed in the beginning of this chapter. It is impossible to identify or isolate one particular causal factor which by itself can

be designated as the responsible precipitating force behind drug abuse in SEA. Rather it is extremely important to understand how these individuals have brought with them to SEA a composite personality which was vulnerable to the drug environment and received the necessary impetus from the combined stress of the specific factors found to be contributory to drug abuse in Southeast Asia.

CHAPTER III

DRUG ABUSE IN THAILAND

Introduction

(U) Although it was indicated in Chapter II that some of the basic causal factors for drug abuse were different in Thailand after the cease-fire, it should be noted that the overall abuse of drugs was quite similar with regard to type of drugs abused and amount of abuse. Statistics have shown a gradual decline in the amount of drug abuse throughout this period of time; however, this decline has been attributed by most of the knowledgeable professionals in this field to "lessons learned" and an improved, more effective drug abuse control program.

(U) This chapter discusses actual drug abuse in terms of incidents and statistics, and presents the drug abuse control program as it has been implemented in Thailand, together with the results of that program.

Drug Abuse Activities

(U) The Flow of Drugs from SEA. A recent report to a congressional committee as discussed in an Associated Press bulletin,[30] stated that a major share of heroin coming to the United States flows almost freely from Thailand, unhampered by many corrupt Thai officials and meager US anti-drug efforts. The report to the House Foreign Affairs Committee was written by Rep. Lester L. Wolff, D-NY, recently named chairman of a special narcotics subcommittee. The report disclosed that of 1,400 tons of opium grown annually, 700 tons came from the Golden Triangle area of Burma, Laos, and Thailand -- with the latter country the key to the trafficking of heroin base and heroin, derivatives of opium. "Thailand...(is) the major

conduit for the flow of opium and its derivatives to the illicit market in Vietnam, Hong Kong, and ultimately to the United States," the report states. It quoted American officials as saying Thai police seldom seized opium caravans "partly because of lack of expertise and partly because of an unwillingness on the part of some officials to exert the effort necessary to intercept the smugglers." Although conceding a lack of manpower, the report added that "much of the blame seems more properly attributable to corruption and lack of cooperation among middle and lower echelon law enforcement officials." It added that Thai police have increased seizures of narcotics, but the information that led to them came from US officials, and the increase has not kept up with the increased volume of heroin traffic in Thailand. Drugs of all types "are readily available throughout Thailand and are widely used by American personnel" stationed there, according to the report. "Reports indicate that heroin can be bought within 100 yards of Udorn Air Force Base, and is readily available to American school-age dependents in Bangkok," it said.

(U) US attempts to gain the cooperation of Thai officials have largely failed, the report said. It cited as an example a plan developed by the United States last October for an aerial photographic survey of Thailand to evaluate opium production and assist in crop substitution planning. But for more than four months, it said,

> Thai officials 'passed the poppy' among themselves on the decision whether to allow the survey to take place. By that time, it was February and the rainy season was beginning and the poppy season was over. In effect, the delay and footdragging of uncooperative Thai officials precluded the usefulness of the mission until it was impossible to use aerial detection...

(U) Essential to stopping the drug traffic, said the report, was the capture of about a dozen Thai trawlers used to smuggle narcotics from Bangkok to other ports -- primarily Hong Kong, which the report described as the center of the Asian narcotics trade. These trawlers sailed unimpeded all year despite official knowledge of their use and the availability of sophisticated detection devices to trap them. Each trawler was capable of carrying the equivalent of about six percent of the annual consumption of heroin. "It is estimated that trawlers bring about 50 tons of opium and its derivatives to Hong Kong ... in some cases, these trawlers offload their deadly cargoes in Communist Chinese waters adjacent to the colony. In other instances, the opium is dropped in offshore waters for future pickup by other vessels." Narcotics control in Hong Kong was difficult with more than 7,000 ships and more than a million air passengers arriving there each year, according to the report. It alleged that the United States, meanwhile, had made only "half-hearted" efforts to cope with the opium-based drug traffic at its source, contending that this has caused Southeast Asian authorities to ignore American agents when they ask for help. Although more than a million Americans served in Vietnam, the report said only 26 Bureau of Narcotics and Dangerous Drugs (BNDD) and six US Customs agents were assigned to Southeast Asia. It urged Congress to furnish funds to train more agents for the newly created Drug Enforcement Administration created by President Nixon's reorganization of drug law enforcement agencies. "Funding ... must be substantially increased to combat a drug flow valued at over $5 billion," the report said.

(U) Use of Drugs by Servicemen in SEA. Another source of information, as reported by the Stars and Stripes Washington Bureau,[31] indicated that the armed forces were well on their way toward settling the drug problem among servicemen and women, but the Defense Department's chief medical officer felt they still had a long way to go. Although drug abuse had attracted news media attention, particularly because of the high rate of use reported among troops during the Vietnam War, Dr. Richard S. Wilbur, assistant defense secretary for Health and Environment, said he was now more concerned about what he called "the legal drug -- alcohol. It will take years to win the war against alcohol," Wilbur stated at a recent briefing on drug abuse.

(U) Based on findings and reports received during a recent worldwide inspection tour, Wilbur also said: Only 1.8 percent of the soldiers and airmen in Germany were found to have used drugs in June 1973 compared to 2.8 percent in January 1973. Only 0.5 percent of the soldiers, airmen, and Marines in Thailand used drugs in June, down from 1.4 percent in January. (Detailed tables are in the Appendix). "These statistics are based on the results of random urinalysis screening of servicemen 28 years old or less," Wilbur explained. "While the trend is down, they are still higher than we would like to see." Through urinalysis, the Armed Forces can detect those who use amphetamines, barbiturates, and opiates (morphine-heroin), although there was no current test then to determine if individuals used marijuana or hashish.

(U) An analysis of statistics on those servicemen apprehended for using drugs shows that the relative use of amphetamines, barbiturates,

and opiates fluctuated from month to month. Starting in late 1971 and running through June, 1972, opiate use represented only 10 percent of the total drug abuse cases, but by late spring, 1973, it accounted for 40 to 50 percent of the total. Another dramatic change occurred between the springs of 1972 and 1973 in that barbiturate use dropped from 40 percent to about 6 percent. Amphetamines remained relatively constant throughout the period at around 50 percent.

(U) Wilbur also said that of the 1.3 million men and women in uniform examined through random urinalysis screening between mid 1972 and mid 1973, only 0.7 percent were clinically confirmed as positive drug users. Here is a breakdown by service: Army - 1.3 percent, Navy - 0.3 percent, Marine Corps - 0.6 percent, Air Force - 0.2 percent. About half of the identified users were treated and returned to duty, the Pentagon official pointed out, while almost one-third were rehabilitated and then separated from the service. About 17 percent were still undergoing treatment at the time the report was prepared, and a little more than 5 percent were transferred to Veterans Administration hospitals for additional treatment. Wilbur said the armed forces would always face a drug problem of some kind. During the draft the services inducted many men who had been drug users in civilian life. Now, through a more elaborate examining process, these men were identified and refused enlistment. Even so, he added, there would always be a certain number of servicemen who would use drugs. They would be rehabilitated or separated from the service.

(U) Significant Occurrences. A number of the following significant occurrences, as reported by the Bureau of Narcotics and Dangerous Drugs,[32]

are presented in chronological order in this report to show the most recent trend and to present more accurately the composite drug abuse picture in Thailand.

(C) A six-month survey of reported narcotics violations involving US servicemen in Thailand during the period July - December 1972 were compiled by the Office of the Provost Marshal, Joint United States Military Advisory Group/Military Assistance Command, Thailand (JUSMAG/MACTHAI). Statistics in the report were of value primarily as an indicator of the relative frequency and type of violation reported from the field by means of Serious Incident Report (SIR) and/or investigations.[33]

(C) Samlar drivers in Ubon, Thailand told their US Air Force customers from the nearby airbase that "Red Rock" was nothing more than a kind of super marijuana. This, of course, was not true. "Red Rock" is in reality No. 3 smoking heroin and is addictive. It is only a few chemical steps away from No. 4 or white powder heroin, the addictive and debilitating product which most people associate with the term "hard drugs." Number 3 smoking heroin is equally addictive and harmful.[34]

(C) From March 1st through 20th, 1973, Thai National Police made a total of 103 drug arrests. Highlights of these arrests were the seizure of 3.2 kilograms of No. 3 heroin in Nakhon Ratchasima, 180 grams of No. 4 heroin in Bangkok, 500 grams of No. 4 heroin in the Chinese sector of Bangkok, and 168 kilograms of raw opium near the Bangkok Harbor complex.[35]

(C) A secret Sino-Thai Youth movement called "Anuvastr Ramruek," comprised of university students of Chinese heritage, vowed to press their community leaders to stamp out Chinese drug trafficking. The movement

stated, "We have found that Chinese have been involved in most of the drug trafficking cases in Thailand. We think no Chinese in this country would want to be branded part of this highly destructive activity. So we stand ready to oppose, prevent, and wipe out the drug problem in this country." Various public and student organizations helped by providing tips for police in arresting youthful addicts. A recent newspaper editorial estimated that there were 400,000 narcotic addicts in Thailand, and calculates that there were not less than 5,000 juveniles in the Bangkok-Thon Buri area who were addicted.[36]

(C) On April 26, 1973, Prime Minister Thanom Kittikachorn handed down a 25 year jail term to former anti-narcotics chief, Pramual Vanigabhandu. Pramual was charged with irregularities and subsequent promotion of the dangerous drug trade, negligence in the arrest and prosecution of narcotics suspects, and extortion of suspects. In sentencing Pramual, the Prime Minister exercised his authority under Article 17 of the interim Constitution which provided for summary proceedings without taking the case to court. It was reported that the decision to use Article 17 was taken because authorities feared that prosecution witnesses might be reluctant to testify against Pramual incourt, and that the case against him might have been dropped.[37]

(C) The capture in South Vietnamese water of a Thai fishing trawler loaded with opium and morphine base provided one of the largest drug seizures ever accomplished in Southeast Asia. During the late afternoon of 19 April 1973, a South Vietnamese Navy destroyer escort interdicted the suspect Thai trawler north and east of Nha Trang, well beyond normal

Thai fishing areas. The trawler had to be fired upon before it would stop for inspection. The vessel was boarded and discovered to be carrying 5,568 kilograms of raw opium and 126 kilograms of morphine base destined for Hong Kong. Eight Thais and one ethnic Chinese resident of Bangkok were arrested and held in custody at Saigon. The trawler was confiscated. An extensive follow-up investigation was conducted by representatives of BNDD, South Vietnamese National Police, Thai National Police, and Hong Kong authorities.[38]

(C) Off base heroin pushers in the Sattahip area were reportedly cutting No. 4 heroin supplies with baking powder before sale to military personnel. This was the first report received by BNDD of No. 4 heroin dilution in Thailand. The dilution or cutting of heroin to increase its volume is a common practice in the US. This development was believed to be an indication of a shortage of heroin in the south of Thailand, not an increase in buyer demand.[39]

(C) Marijuana sniffing dogs at Bangkok's Don Muang Airport proved their effectiveness. Between January, 1973, and October, 1973, 90 pieces of mail suspected of containing marijuana were referred to Customs in the US for follow-up investigations. As of October, 48 confirmations were received and another 33 cases were pending at the writing of this report. The usual amount of marijuana hidden in the mailing envelope or small parcel weighed from 1/4 to 3/4 ounces.[40]

(C) On June 22, a Thai border police and Special Narcotic Organization Task Force launched a joint operation against opium traffickers in the village of Ban Wa Wi, approximately 20 miles northwest of Chiang Rai.

The Task Force was airlifted by helicopter and fixed-wing aircraft into the village at 0600 hours. The Task Force confiscated 66 kilos of raw opium, 67 kilos of morphine base (999), 700 grams of No. 4 (New Lion Brand), 11 kilos of No. 3 heroin, 2 kilos of smoking heroin, and 12 kilos of opium ash. In addition, 13 rifles and handguns were seized.[41]

(C) From January 1, 1973, to June 1973 the Royal Thai Government (RTG) compiled an impressive record in enforcement actions ranging from the Gulf of Thailand to the northern provinces. A total of 11,966 kilograms of raw opium was seized. In addition, 510 kilograms of morphine base, 38.5 kilograms of heroin No. 4, 124 kilograms of prepared (smoking) opium, and 16.5 kilograms of smoking heroin No. 3 were confiscated.[42]

(C) The months of July and August were highlighted by the arrest of Lo Hsing Han, the reputed "Opium King of the Golden Triangle," on July 17, 1973, and his subsequent extradition to Burma on August 2, 1973. Lo was charged with armed rebellion, arms smuggling, and drug trafficking.

(C) Lu Peng Khia, another leading narcotic trafficker, and two of his associates were also arrested by Thai Police on July 10, 1973. Follow-up investigation by Narcotic Suppression Center, Crime Suppression Division, and Marine Police resulted in the recovery of 80 kilograms (57 bricks) of morphine base, 999 brand, contained in three burlap bags. The contraband which belonged to Lu was hidden in the jungle outside of Chumphon City in southern Thailand. This is near the area where 2,520 kilograms of raw opium was found on July 21, 1973. It is expected that the RTG will use Article 17, a non-judicial proceeding, in disposing of this case.[43]

(C) As a result of these arrests and seizures, the street prices of illicit drugs in Bangkok and elsewhere in Southeast Asia rose, and there was growing reluctance on the part of both dealers and suppliers to conduct their narcotic transactions on a "business as usual" basis.[44]

(C) On July 3, 1973, Special Narcotics Organization (SNO) forces stopped a small bus suspected of narcotics smuggling at a roadblock on Highway 1 south of Chiang Rai and seized 97.5 kilograms of Double Rabbit brand smoking opium. The opium was contained in 75 paper bags hidden under a seat in the suspect mini-bus. This contraband was destined for delivery to Bangkok.

(C) On August 24, 1973, SNO forces garrisoned at Lampang, acting on their own intelligence, intercepted and seized 138 kilograms of morphine base that were concealed in a Toyota sedan. Two defendants were arrested and the vehicle impounded. Thai Narcotic Suppression officials in Bangkok followed the case with interest since the vehicle involved was registered to a Provincial Police official.[45]

(U) Tables 5 and 6 list the availability and price of No. 4 heroine for July and August 1973, further emphasizing the importance of the availability factor to drug abuse in SEA.

(U) Tables 7 and 8 show a narcotics breakdown on drug abuse (H-heroin, DD-dangerous drugs, M-marijauna), by base and by service (Air Force, Army).

(U) The incidents and statistics presented thus far give an indication of the drug abuse activity currently in SEA, and especially Thailand. However, this writer recognizes, through his clinical contact with many drug abusers, that much drug activity is not reported. Drug abuse will continue although it is apparently being better controlled as current drug abuse programs improve and new ones are implemented.

TABLE 5

AVAILABILITY & PRICE OF ILLICIT DRUGS - JULY 1973

NO. 4 HEROIN

			AMOUNT	QUALITY	PRICE
1.	Bangkok	R	700 Grams	Bulk Sales	$1,500 - $1,600
		W	700 Grams	95%	$1,000 - $1,100
2.	Ban Houei Sai	R			
		W	700 Grams		$ 700 - $ 800
3.	Chiang Mai	R	700 Grams	95%	$ 400
		W			
4.	Hong Kong	R	60 Mg.	80%	$ 1.00
		W	Per Kilo	99 + %	$5,644
5.	Kuala Lumpur	R			
		W	1 Pound	95%	$1,450
6.	Pakse	R			
		W	700 Grams		$1,600
7.	Saigon	R	70 Mg.	80%	$ 2.00
		W	1 Kilo	90%	$3,600
8.	Singapore	R			
		W	1 Kilo	95%	$3,000
9.	Tachilek/Mae Sai	R			
		W	1 Kilo		$1,000
10.	Vientiane	R			
		W	1 Kilo		$1,000 - $1,150

R - Retail 1 Kilo = 1,000 grams

W - Wholesale 1 Kilo = 2.2 pounds

SOURCE: Narcotics Bulletin Southeast Asia, Bureau of Narcotics and Dangerous Drugs Regional Office, US Embassy, Bangkok, Thailand, Jul-Aug 73. (U)

TABLE 6

AVAILABILITY & PRICE OF ILLICIT DRUGS - AUGUST 1973

NO. 4 HEROIN

			AMOUNT	QUALITY	PRICE
1.	Bangkok	R	Per Kilo	94%	$2,400 - $2,900
		W	700 Grams		$1,400 - $1,800
2.	Ban Houei Sai	R			
		W	700 Grams		$ 700 - $ 800
3.	Chiang Mai	R			
		W	Per Kilo	95%	$1,101
4.	Hong Kong	R	60 Mg.	80%	$ 2.00
		W	Per Kilo	99 + %	$6,600
5.	Kuala Lumpur	R			
		W	1 Pound	95%	$1,812
6.	Pakse	R			
		W	700 Grams		$1,600
7.	Saigon	R	70 Mg.	80%	$ 2.00
		W	1 Kilo	90%	$4,200
8.	Singapore	R			
		W	1 Kilo	95%	$3,000
9.	Tachilek/Mae Sai	R			
		W	1 Kilo		$1,000
10.	Vientiane	R			
		W	1 Kilo		$1,000 - $1,150

R - Retail 1 Kilo = 1,000 grams
W = Wholesale 1 Kilo = 2.2 pounds

NOTE: The jump in price is due to shortages caused in large measure by increasingly effective enforcement actions being taken in Thailand and Burma.

SOURCE: Narcotics Bulletin Southeast Asia, Bureau of Narcotics and Dangerous Drugs Regional Office, US Embassy, Bangkok, Thailand, Jul-Aug 73. (U)

TABLE 7

AIR FORCE NARCOTICS BREAKDOWN - JUL-DEC 72

BASE LOCATION	CASE REPORTED	ON POST	OFF POST	SUSPECTS	TYPES OF DRUGS H	DD	M	REMARKS (ORIGIN OF CASE)--
U-Tapao	27	9	18	50	5	1	44	16 Thai Police 9 Security Police 2 Customs Insp
Takhli	27	14	13	37	4		33	12 Thai Police 15 Security Police
NKP	26	21	5	33	3		30	18 Security Police 2 Customs Insp 6 Thai Police
Udorn	22	2	20	25	4	1	20	13 Thai Police 4 Customs Insp 5 Security Police
Ubon	19	5	14	37	3	1	33	13 Thai Police 6 Security Police
Korat	13	4	9	16			16	9 Thai Police 3 Security Police 1 Customs Insp
Don Muang	2	2		2			2	2 Security Police
Total	136	57	79	200	19	3	178	69 Thai Police 58 Security Police 9 Customs Insp

SOURCE: Data provided by Drug Abuse Control Officer, Udorn RTAFB, Nov 73. (U)

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TABLE 8

ARMY NARCOTICS BREAKDOWN - JUL-DEC 72

BASE LOCATION	CASES REPORTED	ON POST	OFF POST	SUSPECTS	TYPES OF DRUGS H	DD	M	REMARKS (ORIGIN OF CASE)
Sattahip	28	20	8	42	12		30	17 Military Police 8 Thai Police 1 Overdose 2 Unit Search
Bangkok	9	7	2	10	8	1	1	3 Military Police 3 Hospital Search 1 Overdose 1 Thai Police 1 Unit Search
Udorn	9	3	6	11	1	1	9	5 Thai Police 3 Unit Search 1 Military Police
Lopburi	1	1		2			2	1 Unit Search
Total	47	31	16	65	21	2	42	21 Military Police 14 Thai Police 7 Unit Search 2 Overdose 3 Hospital Search

SOURCE: Data provided by Drug Abuse Control Officer, Udorn RTAFB, Nov 73. (U)

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The Drug Abuse Control Program

(U) Definitions. Pacific Air Forces Manual (PACAFM) 30-12,[46] dated 16 May 1973, outlines the procedures and requirements for the Drug Abuse Control Program in PACAF and is, therefore, the major guide for the program in Thailand.

(U) It is appropriate at this point to identify some terms which are used in this report and which are identified by PACAFM 30-12[47] as:

a. Drugs - In general terms, any of the narcotics, marijuana, or dangerous drugs defined in AFR 30-19, attachment 1, 30 July 1971. (See Table 9 for detailed list).

b. Dangerous Drugs - Those non-narcotic drugs that are habit-forming or have a potential for abuse because of their stimulant, depressant, or hallucinogenic effect, as determined by the Attorney General of the United States. This category includes, but is not limited to, amphetamines, barbiturates, lysergic acid diethylamide (LSD), mescaline, demethoxyamphetamine (STP), and psilocybin.

c. Narcotics - Any opiates or cocaine, including their synthetic equivalents.

d. Marijuana - The intoxicating products of the hemp plant, cannabis sativa (including hashish), or any synthesis thereof. Marijuana is a drug which has no known beneficial use. Its use, possession, transfer, or sale is prohibited by law.

e. Drug Abuse - The illegal, wrongful, or improper use of any narcotic substance, marijuana, or dangerous drugs, or the illegal or wrongful possession, transfer, or sale of same.

TABLE 9

GUIDE TO DANGEROUS DRUGS, NARCOTICS, AND MARIJUANA

Dangerous Drugs. All drugs prohibited within AFR 30-19 are dangerous in the general sense. However, the specific category, "dangerous drugs," as defined in paragraph 1 of the regulation, is established to include all those drugs that are dangerous in improper use, but are not specifically prohibited by the Uniform Code of Military Justice (UCMJ), such as narcotics and marijuana. Listing and prohibiting the use of these substances in AFR 30-19 makes their improper use a violation of UCMJ Article 92(a), "Failure to Obey or Regulation," While the following is not an all-inclusive list of the dangerous drugs specified in paragraph 1a or included in Title 21, Code of Federal Regulations, it includes those drugs most commonly being abused.

Name	Slang Name	Chemical or Trade Name	Classification	How Taken	Effect Sought
Barbiturates	Barbs Blue Devils Yellow Jackets Blue Heavens Downers Peanuts	Phenobarbital Nembutal Seconal Amytal	Sedative-hypnotic	Swallowed or injected	Anxiety reduction; euphoria
Amphetamines	Bennies Dexies Speed Hearts Uppers Pep Pills Peaches	Benzedrine Dexedrine Desosyn Methamphetamine Methedrine	Stimulant	Swallowed or injected	Alertness activeness
DMT	AMT Businessman's High Lunch-Hour Special	Diemethyl-triptamine	Hallucinogen	Injected	Exhilaration; distortion of senses
LSD	Acid Sugar Big D Cubes Trips Royal Blue	Lysergic acid diethylamide	Hallucinogen	Swallowed	Insightful experiences; distortion of senses
STP	DOM Serenity Peace	4-Methyl-2 demethoxy-amphetamine	Euphoriant; in large doses a hallucinogen	Swallowed	Euphoria; distortion of senses
Mescalin	Mesc	3, 4, 5 trimeth oxyphenethylamine	Hallucinogen	Swallowed	Exhilaration; distortion of senses
Psilocybin		8 (2-dimethyl-amine) ethylindol—4-oldihydrogen phosphate (derived from mushrooms)	Hallucinogen	Swallowed	Exhilaration; distortion of senses
Narcotics					
Cocaine	Gold Dust Coke Snow	Methylester of benzoylecgenine	Stimulant	Sniffed, injected, or swallowed	Excitation

SOURCE: AFR 30-19, 30 July 1971, Attachment 1. (U)

Name	Slang Name	Chemical or Trade Name	Classification	How Taken	Effect Sought
Codeine	Schoolboy	Methylmorphine	Narcotic	Swallowed	Euphoria; prevent withdrawal discomfort
Heroin	H. Horse Junk Smack Scag Stuff Harry	Diacetyl Morphine	Narcotic	Sniffed or injected	Euphoria; prevent withdrawal discomfort
Methadone	Dolly	Dolophine Amidone	Narcotic	Swallowed or injected	Prevent withdrawal discomfort
Morphine	White stuff "M"	Morphine sulphate	Narcotic	Swallowed or injected	Euphoria; prevent withdrawal discomfort
Marijuana					
Hashish	Hash	Cannabis sativa (in a concentrated form)	Relaxant; euphoriant; in large doses a hallucinogen	Smoked	Relaxation; increased euphoria; sociability
Marijuana	Pot Grass Tea Reefers Joints	Cannabis sativa	(as above)	Smoked Swallowed	(as above)

(1) Drug Experimenter - One who has illegally, wrongfully, or improperly used any narcotic substance, marijuana, or dangerous drug, as defined heroine, not more than a few times for reasons of curiosity, peer pressure, or other similar reason. The exact number of usages is not necessarily as important in determining the category of the user as is the user's intent, the circumstances of use, and the user's psychological make-up. Final determination of the category must be made by the unit commander, based on the advice of medical, legal, and social actions personnel.

(2) Drug User - One who illegally, wrongfully, or improperly used any narcotic substance, or dangerous drug, as defined herein, generally several times and for reasons of a deeper and more continuing nature than those motivating the drug experimenter. Final determination of the category must be made by the unit commander based on the advice of medical, legal, and social actions personnel.

(3) Drug Addict - One who exhibits a behavioral pattern of compulsive drug use, characterized by overwhelming involvement with the use of drug and securing its supply. As the term drug addict is used herein, one may or may not be physically dependent on the drug. Rather, the term refers in a quantitative sense to the degree to which drug use pervades the user's total life activity.

g. Smuggling - Any clandestine introduction into, or removal from a country, of goods in violation of law or regulation, or of goods on which the duty has not been paid, or that have not been declared or invoiced.

h. Supplier - One who furnishes illegally, wrongfully, or improperly to another person a small amount of any of the drugs defined herein

for the convenience of the user rather than for gain.

Education

(U) The drug abuse education programs in Thailand have been reasonably successful, but at this point, it seems a bit premature to make an absolute assessment. Generally the education program for the prevention of drug abuse provided a very adequate presentation for the potential abuser as well as the supervisor. The mandatory education programs included:

a. Incoming Drug Briefing - A special briefing given to all military personnel, US civilian personnel, and dependents (above 8 yrs of age) within the first 2 weeks of their arrival in the overseas theater. (Attendance of dependents was optional but was strongly encouraged.)

(1) As a minimum, the briefing provided at least 2 hours of comprehensive drug training.

(2) Briefing included, but was not limited to, presentations by:

(a) Medical Personnel - explained physiological and psychological dangers inherent in drug use.

(b) Judge Advocate - explained what disciplinary actions might result from drug abuse. Insured all personnel understood clearly the applicable foreign drug laws and possible penalties that may result from drug offenses, particularly to smuggling or involvement of local nationals. Coverage also included foreign laws in other PACAF areas to which personnel might travel on leave or temporary duty during a tour.

(c) Chaplains - accented the moral implications of drug abuse and the consequent dangers to ethical conduct.

(d) Drug Abuse Control Officer - stressed the inconsistency between drug usage, military responsibility, and national security as well as the implications of drug usage in security determinations, administrative discharge actions, and line of duty determinations. Explained the local drug abuse program and how, when, and why assistance could be obtained.

(e) Drug Abuse Control Officer/Security Police - explained the drug environment of the local community. This included a frank assessment of what drugs were available and what dangers were inherent in local drugs.

b. Annual Drug Abuse Education - A minimum of 2 hours of drug abuse education was provided at least annually for all military and civilian personnel. Every installation conducted vigorous and well planned drug education sessions designed to provide:

(1) Knowledge of drugs and effects of abuse.

(2) Knowledge of conditions which promote drug abuse.

(3) Sensitivity to the needs of individuals.

(4) Constructive alternatives to drug use (for example, sports programs, civic actions programs, etc.).

(5) Knowledge of Air Force policies and procedures for assistance and disposition of drug abusers.

c. The drug education provided during the incoming briefing (a, above), might be considered the annual training for that year.

d. Unit commanders insured that mandatory training for military personnel was recorded on AF Form 572, "General Military Training Record,"

and training for civilian employees was documented in accordance with applicable civilian personnel regulations.

e. Drug Departure Briefing - Military personnel and civilian employees completing their tour of duty or being reassigned received a short outbriefing. Primary purpose of this briefing was to stress the consequences of drug smuggling and the transportation of illegal drugs. The use and intent of amnesty boxes at aerial ports was also explained.

(U) Additionally, voluntary, supplementary education programs were provided by individual installations beyond the above requirements. For example, US military commanders were urged to publicize widely the extent of penalties (Table 10) that Thailand courts can levy for possession or handling of drugs. Section 20 of the Harmful Habit-Forming Drug Act B.E. 2465, Thailand Criminal Code, stated that whoever bought, took, or possessed heroin or its hydrochloride would be imprisoned from one to ten years and fined not to exceed 10,000 Baht ($500). As of March 31, 1973, three Armed Forces personnel were confined to Thai prisons serving one-year terms for possession of heroin.

The Five Phase Program

(U) The drug abuse control program consisted of five phases as outlined by PACAFM 30-12.[48]

a. Identification - through urinalysis, the Limited Privileged Communications Program, identification incident to medical care, and apprehension or investigation.

b. Detoxification - a medical procedure sometimes required to eliminate physical dependence on drugs.

TABLE 10

DRUG OFFENSES IN THAILAND

The following are the maximum punishments imposable upon conviction of the listed drug offenses which are in violation of the Penal Code of Thailand.

DRUG CATEGORY	OFFENSE	MAXIMUM PUNISHMENT
Marijuana	Use, possession, and sale	Imprisonment for not more than 6 months. A fine of not more than 200 Baht, ($10) or both.
Opium	Use	Imprisonment from 1 to 10 years and a fine of not more than 10,000 Baht ($500).
	Possession	Imprisonment from 6 months to 10 years and a fine of not more than 5,000 Baht ($250).
	Sale	Imprisonment from 1 to 20 years and a fine of twenty times the value of the opium sold but not less than 5,000 Baht ($250)
Heroin	Use	Imprisonment from 2 to 10 years and a fine of not more than 20,000 Baht ($1000).
	Possession	Imprisonment from 1 to 10 years and a fine of not more than 10,000 Baht ($500).
	Sale	Imprisonment from 5 years to life and a fine of not less than 50,000 Baht and not more than 500,000 Baht ($2,500 to $25,000)

NOTE: If the accused is found to be a distributor or agent for a distributor the maximum penalty is DEATH.

TABLE 10 -- Continued

DRUG CATEGORY	OFFENSE	MAXIMUM PUNISHMENT
Other Dangerous Drugs	Use	Imprisonment from 6 months to 10 years and a fine of not more than 5,000 Baht ($250).
	Possession	Imprisonment from 3 months to 5 years and a fine of not more than 2,000 Baht ($100).
	Sale	Imprisonment from 6 months to 10 years and a fine of ten times the value of the drug sold but not less than 3,000 Baht ($150).

SOURCE: Data provided by Drug Abuse Control Officer, Udorn RTAFB, Nov 73.

c. Psychiatric Evaluation and Treatment - a medical procedure to determine emotional and social potential for rehabilitation and appropriate treatment and disposition.

d. Behavioral Reorientation (Rehabilitation - a nonmedical voluntary treatment period to motivate the individual to forego the use of drugs. It usually involved counseling and concluded with a determination of the individual's motivation and potential for further rehabilitation or whether he should be separated or referred to a central treatment facility.)

e. Follow-on Support - a nonmedical voluntary rehabilitation phase of 1 year duration in which the individual was returned to normal duties while being monitored and evaluated. It included counseling or other support, as needed, to help avoid return to use of drugs.

(U) Identification (Phase I). In accordance with PACAFM 30-12[49] the first step in the process of drug abuse control was to identify the experimenter, user, and addict. This was accomplished through a program in which the individual reported himself, the Limited Privileged Communications Program (LPCP), or through urinalysis, identification incident to medical care, and apprehension or investigation.

a. Limited Privileged Communication Program. An Air Force member who voluntarily presented himself to his commander, first sergeant, social actions, or medical personnel for treatment and rehabilitation in regard to his personal use of drugs, or possession incident thereto, was granted certain limited privileged communication rights. The limits of protection applied only to service members who voluntarily revealed the nature and extent of their drug use and sought treatment prior to receipt of a

laboratory positive urine test, being apprehended, placed under investigation, or advised of action to recommend them for administrative separation because of their use of drugs. Personnel were considered to be under investigation when a written request for investigation was made to either the security police or the Air Force OSI. Investigations normally were not initiated on members as a result of their seeking assistance under LPCP. The purpose of the LPCP was to encourage drug users to identify themselves so that they could be helped. Actions counterproductive to this were taken only when the value to be gained was expected to clearly outweigh the possible negative impact on the exemption program.

b. Urine Testing Program. The stated purpose of this program, called Golden Flow, was to identify persons who required treatment and rehabilitation services, derive data regarding the prevalence of drug abuse, and provide a degree of deterrence.

(1) DEROS - Thailand DEROS urine tests were accomplished within 45 days prior to rotation. Testing was accomplished to allow time for test results to be received and 4 weeks of followup testing to be completed if necessary to confirm a laboratory positive. Individuals subject to DEROS testing were given minimum advance notice.

(2) Drug Rehabilities - Individuals in phase IV of the base level rehabilitation program were tested three times per week until completion of this phase. Individuals in phase V were urine tested twice monthly.

(3) Commander-Directed Testing - Commanders were encouraged to seek out drug abusers by staying alert for indications of drug abuse

such as decreased job performance, loss of interest in personal appearance, excessive loss of weight, and increased lateness for duty. Individuals suspected of drug usage were directed by their unit commanders to provide a urine sample to medical personnel for analysis. This category of testing has proven to be an extremely effective method of identifying drug abusers. Individuals referred to commanders for suspect testing were personally interviewed by commanders prior to the specimen testing.

(4) Unit Testing - Numbered air force commanders had the authority to authorize testing of entire squadrons, work centers, or shifts when it was locally determined that pockets of drug abusers might be identified. Unit testing was directed only when the immediate commander had reason to suspect unidentified drug abusers in a squadron or work center, and not as a routine practice.

(5) Random Testing - The reader is directed to PACAFM 30-12[50] for the detailed description of this procedure.

Sample collections were conducted as follows:

(a) Individuals on prescribed medication. Personnel giving urine samples were informed in writing that use of any opiates, barbiturates, or amphetamines would show positive test results. Personnel on medication prescribed by a physician were required to so indicate in writing to the collection monitor. Their statement was provided to the base program monitor for use when a test positive result was received on these individuals.

(b) Security. A monitor was required at the collection facility to authenticate the credentials of the individuals providing the

urine (that is, physical features checked against Department of Defense Form 2AF, signature validation, etc.) and to insure authenticity of the sample. This individual also annotated the roster provided by the test monitor. A thorough body search was authorized to preclude substitution of another individual's urine (that is, substitution of pre-filled urine bottles, use of plastic or rubber tubing, etc.).

(c) Observation. All submissions of urinalysis specimens are visually observed from the front side (to preclude sample substitution). No more than two individuals were observed by the same observer. Clinical processing of the urine samples is covered in PACAFM 30-12.

c. Identification Incident to Medical Care. Individuals who were receiving medical treatment, whether as in-patient or out-patient might display signs of drug usage or have occurrences of withdrawal symptoms. In most cases, withdrawal symptoms were very mild and the physician was constantly alert for individuals using illegal drugs.

Attending physicians tried to determine, by the individual's medical history and clinical observation, if the member was a drug abuser. Those individuals who were clinically confirmed as illegally using a drug were detoxified or entered into base level rehabilitation. Those patients suspected of drug abuse, but for whom the attending physician could not make a clinical determination, were entered into the urinary surveillance program and tested three times a week for eight consecutive weeks.[51]

d. Identification by Apprehension or Investigation. All incidence of drug abuse requiring investigation were referred to the local OSI, through the local security police agency, as prescribed by Air Force

Regulations (AFRs) 124-11, 124-12, and 125-21. Personnel involved in drug abuse investigations were referred to the local medical facility for determination of illegal drug usage. For personnel involved in investigations or incidents other than drug abuse, the commander determined if referral to medical authorities for illegal drug usage was appropriate. Attending physicians try to determine, by a review of the individual's medical history and clinical observation, if the member was a drug abuser. Those individuals clinically confirmed as illegally using a drug were processed as described previously. Those individuals for whom the evaluating physician could not make a clinical determination were entered into the urinary surveillance program and tested three times a week for eight consecutive weeks.[52] Regardless of the source of identification, members identified as having used drugs were medically evaluated at the local medical facility.

Phase I was implemented effectively and was one of the most critical aspects of the drug abuse control program.[53] Tables 11 and 12 show the cumulative and monthly results of the identification program. Greater detail is available to the reader by referring to Tables presented in the Appendix. Of course statistics are only as good as the method of collection. Some of these are therefore questionable in that not every medical facility and officer clinically confirms positives in exactly the same manner. Also, it is the opinion of most professionals in the drug abuse control program that the entire process of identification has become more efficient, thereby providing a contaminant variable in assessing an accurate rate of decline in actual drug abuse, as previously indicated.

TABLE 11

OSI STATISTICS ON DRUG ABUSE - THAILAND

MONTH	NO. OF INVEST	NO. OF SUBJS	MARI-JUANA	HEROIN	AMPHET-AMINES	NOT IDEN-TIFIED	BARBI-TURATES	OTHER	LSD	OTHER HAL-LUCINOGENS	MOR-PHINE	OPIUM	COCAINE
Aug 71	21	35	33	2	0	0	0	0	0	0	0	0	0
Sep 71	14	20	15	2	2	0	0	0	0	0	0	0	1
Oct 71	7	7	3	0	2	0	2	0	0	0	0	0	0
Nov 71	12	21	21	0	0	0	0	0	0	0	0	0	0
Dec 71	7	7	4	1	1	0	0	1	0	0	0	0	0
Jan 72	16	29	16	7	4	0	2	0	0	0	0	0	0
Feb 72	9	12	10	2	0	0	0	0	0	0	0	0	0
Mar 72	16	25	18	2	1	0	2	0	1	0	0	1	0
Apr 72	10	28	18	3	1	0	2	4	0	0	0	0	0
May 72	19	29	11	6	2	0	2	0	0	0	0	8	0
Jun 72	44	36	19	7	4	0	5	0	0	0	0	1	0

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TABLE 11 - CONTINUED

MONTH	NO. OF INVEST	NO. OF SUBJS	MARI-JUANA	HEROIN	AMPHET-AMINES	NOT IDEN-TIFIED	BARBI-TURATES	OTHER	LSD	OTHER HAL-LUCINOGENS	MOR-PHINE	OPIUM	COCAINE
Jul 72	14	91	64	14	10	0	3	0	0	0	0	0	0
Aug 72	28	49	32	8	2	0	0	1	3	0	2	1	0
Sep 72	25	52	27	17	3	0	1	0	0	0	0	3	1
Oct 72	25	46	23	11	6	0	3	1	2	0	0	0	0
Nov 72	16	20	13	4	3	0	0	0	0	0	0	0	0
Dec 72	24	31	22	7	0	1	0	0	0	0	0	1	0
Jan 73	33	54	34	12	5	1	1	0	0	1	0	0	0
Feb 73	11	20	16	4	0	0	0	0	0	0	0	0	0
Mar 73	19	36	23	7	2	0	0	3	0	0	0	1	0
Apr 73	17	30	19	3	5	3	0	0	0	0	0	0	0
May 73	25	42	29	12	1	0	0	0	0	0	0	0	0

TABLE 11 - CONTINUED

MONTH	NO. OF INVEST	NO. OF SUBJS	MARI-JUANA	HEROIN	AMPHET-AMINES	NOT IDEN-TIFIED	BARBI-TURATES	OTHER	LSD	OTHER HAL-LUCINOGENS	MOR-PHINE	OPIUM	COCAINE
Jun 73	27	44	38	3	3	0	0	0	0	0	0	0	0
Jul 73	25	58	38	13	6	0	1	0	0	0	0	0	0
Aug 73	11	20	10	10	0	0	0	0	0	0	0	0	0
TOTAL	475	842	556	157	63	5	24	10	6	1	2	16	2

UNCLASSIFIED

SOURCE: Msg, OSI Hq PACAF to OSI Hq Bangkok, Subj: Drug Abuse Statistics (Thailand and Vietnam) Nov 73.

TABLE 12

OSI STATISTICS ON DRUG ABUSE - VIETNAM

MONTH	NO. OF INVEST	NO. OF SUBJS	MARI-JUANA	HEROIN	AMPHET-AMINES	NOT IDEN-TIFIED	BARBI-TURATES	OTHER	LSD	OTHER HAL-LUCINOGENS	MOR-PHINE	OPIUM	COCAINE
Aug 71	36	44	30	12	0	1	1	0	0	0	0	0	0
Sep 71	42	54	28	22	0	3	0	1	0	0	0	0	0
Oct 71	22	33	20	12	1	0	0	0	0	0	0	0	0
Nov 71	22	40	31	9	0	0	0	0	0	0	0	0	0
Dec 71	15	22	10	12	0	0	0	0	0	0	0	0	0
Jan 72	15	29	22	7	0	0	0	0	0	0	0	0	0
Feb 72	5	9	7	2	0	0	0	0	0	0	0	0	0
Mar 72	12	24	7	14	0	0	0	1	1	1	0	0	0
Apr 72	15	28	13	13	0	0	1	1	0	0	0	0	0
May 72	19	33	11	11	1	0	1	0	0	0	0	0	0
Jun 72	7	8	7	1	0	0	0	0	0	0	0	0	0
Jul 72	6	10	6	3	1	0	0	0	0	0	0	0	0

UNCLASSIFIED

TABLE 12 - CONTINUED

MONTH	NO. OF INVEST	NO. OF SUBJS	MARI-JUANA	HEROIN	AMPHET-AMINES	NOT IDEN-TIFIED	BARBI-TURATES	OTHER	LSD	OTHER HAL-LUCINOGENS	MOR-PHINE	OPIUM	COCAINE
Aug 72	2	3	2	0	0	0	0	0	0	0	0	0	0
Sep 72	8	15	4	6	2	1	0	0	0	0	1	1	0
Oct 72	13	18	11	4	0	1	1	0	0	0	0	1	0
Nov 72	12	20	8	11	0	1	0	0	0	0	0	0	0
Dec 72	5	9	3	5	0	0	1	0	0	0	0	0	0
Jan 73	1	3	3	0	0	0	0	0	0	0	0	0	0
Feb 73	8	17	9	4	0	0	0	0	0	0	0	0	0
Mar 73	3	7	7	0	0	0	0	0	0	0	0	0	0
Apr 73	2	2	2	0	0	0	0	0	0	0	0	0	0
May 73	Through Aug 73 -- No Statistics Available -- Bases Closed												
TOTAL	270	428	241	148	5	7	5	3	1	1	1	2	0

SOURCE: Msg, OSI Hq PACAF to OSI Hq Bangkok, Subj: Drug Abuse Statistics (Thailand and Vietnam), Nov 73.

UNCLASSIFIED

(U) Detoxification (Phase II). Any individual who was illegally using drugs to any degree (that is, who had clinically been confirmed positive for drug abuse), had to be evaluated locally and, if necessary, had to undergo physiological detoxification. The purpose of this phase was to totally eliminate any physical dependence on drugs. Secondary, medical effects of drug use might also be diagnosed and treated at the same time. Necessity for participation in Phase II was determined by medical authority.[54]

(U) The two categories of individuals who underwent physiological detoxification were broadly defined as follows:[55]

a. The individual who did not require psychiatric evaluation. Such an individual showed a confirmed positive urine test; however, medical evaluation resulted in a recommendation for immediate entry into local rehabilitation. Such an individual showed no physical or emotional signs of withdrawal and was normally categorized as an experimenter.

b. The individual who required further psychiatric evaluation. Medical evaluation in these cases resulted in transfer to a central detoxification facility or treatment in local detoxification.

(U) In those cases where more detailed psychiatric evaluation was required, or the patients could not be managed locally, they were referred to a central detoxification facility.[56] Fifth Air Force personnel were sent to USAF Hospital Tachikawa, Tachikawa Air Base (AB), Japan; Thirteenth Air Force personnel were sent to USAF Hospital Clark, Clark AB, Philippines; and 15th Air Base Wing personnel were sent to Tripler Army Medical Center, Hawaii. In all referral cases, detailed information was provided including history, physical findings, and symptoms or findings after clinical

confirmation of drug abuse to assist the detoxification staff in establishing a diagnosis and making disposition.

(U) Whenever possible, local detoxification was preferable to referral to a central detoxification facility. This expedited initial rehabilitation efforts, return to duty, or other disposition such as transfer to USAF Special Treatment Center or administrative separation. When detailed psychiatric evaluation was not required and the drug abuser could be detoxified locally, transfer to the USAF Special Treatment Center, Lackland Air Force Base, Texas, could be made directly from a base. Advance approval was required from the USAF Special Treatment Center.[57]

(U) Psychiatric Evaluation and Treatment (Phase III). The objective of this phase was to determine appropriate treatment and disposition for each individual. Where a psychiatric evaluation was required but not practical locally, individuals were referred to a psychiatric referral hospital. In determining a candidate's potential for rehabilitation it was essential the individual be well motivated and demonstrate the emotional and social potential to benefit from a behavioral reorientation type of program.[58]

(U) Rehabilitation (Phase IV). The Air Force's responsibility to its people and to society is to help the drug abuser break his habit and become a normal, productive member of the service community. The extent of individual rehabilitation is limited only by the member's willingness and capacity for rehabilitation, and time remaining in service. Rehabilitation includes any treatment required: detoxification, psychiatric evaluation, medical treatment, and behavioral reorientation at the local level or

at the USAF Special Treatment Center, as appropriate.[59]

(U) Additional guidance was provided by AFR 30-19,[60] Illegal or Improper Use of Drugs, 11 Oct 73, for the rehabilitation and disposition of drug dependent personnel:

> When members are drug dependent, or long term rehabilitation (over 90 calendar days treatment before return to duty) is necessary, they must be processed for separation and transferred to a Veterans' Administration hospital for further treatment. They should be transferred at least 15 calendar days before the effective date of separation.

(U) Local rehabilitation was provided in two phases,[61] Phase IV (Behavioral Reorientation) and Phase V (Follow-on Support and Return to Duty). Phase IV as a nonmedical 3-6 week program of concentrated counseling and education. This time was utilized for a full evaluation of the case and a determination of the appropriate action to be taken. This included a determination whether or not the individual would enter Phase V or local rehabilitation, and how much or what kind of counseling or other treatment might be required if he entered into Phase V. Phase V was the process by which successful Phase IV rehabilitees are provided follow-on rehabilitative support as required. Its maximum duration was one year from the date of entry. The rehabilitation team could, however, recommend completion at any time while the rehabilitee was in Phase V. The rehabilitee's unit commander made the final determination.

(U) The first step in the rehabilitation process is identifying the potential rehabilitee. This was accomplished primarily through urinalysis, apprehension or investigation, the Limited Privileged Communication Program,[62] and identification incident to medical care.

(U) Upon notification from the base program monitor of an identified confirmed drug abuser, the base drug officer contacted the individual within 24 hours. He explained in detail the rehabilitation program and arranged a meeting with the rehabilitation team. This meeting was within 72 hours. The drug abuse officer counseled the individual concerning volunteering for rehabilitation. The individual signed a statement of participation in rehabilitation.[63]

(U) Decisions on the required rehabilitation for program volunteers, the adequacy of rehabilitation progress, and/or disposition of identified drug abusers was made by a rehabilitation team. Personnel required for the rehabilitation team included the following:[64]

a. Drug Abuse Control Officer

b. Unit Commander

c. Physician

d. Others. This included any individuals who have been directly involved in the case and who have pertinent knowledge of the individual, such as a chaplain or judge advocate.

The operation of this team included five basic objectives:

a. Interview and counsel each newly identified drug abuser to determine the nature and extent of his drug involvement.

b. Decide on an appropriate, initial course of action:

(1) Retention on base for local rehabilitation.

(2) Referral to the USAF Special Treatment Center.

(3) Separation from the service.

c. Determine the amount and type of counseling, treatment, and

other supportive activities (for example, education) that seem appropriate.

d. Meet as scheduled by the drug abuse control officer to review and evaluate each rehabilitee.

e. Report to the drug abuse control committee on the status of the base rehabilitation program.

(U) Follow-on Support (Phase V). The primary purpose of Phase V[65] was a demonstration by the member that he could function normally, perform his duties, and meet his responsibilities. Failure to meet this requirement was a basis for separation. To this end, each Phase V rehabilitee was evaluated quarterly for one year by the rehabilitation team. Recommendations for retention or separation were made at these evaluations. Therefore, while the period of successful Phase V rehabilitation was one year, members could be recommended for separation at earlier evaluations based on lack of progress. Failure to be recommended for unconditional retention at the final evaluation was a basis for initiating separation action. The final evaluation had to include a medical officer's evaluation.

(U) Each Phase V rehabilitee received a final evaluation by the rehabilitation team. If the final evaluation revealed the individual to be fully rehabilitated, restrictions as to reenlistment, assignment, and promotion were removed and all tracking data in the personnel data system eliminated. Any drug user returned to the Continental United States for separation or retirement was counseled by the base drug abuse control officer on Veterans' Administration and National Institute of Mental Health facilities nearest his home of record, where he could receive further treatment and assistance

if desired. All drug dependent personnel, and those personnel within 30 days of expiration of term of service from the Air Force, were provided a minimum of 30 days in a drug free environment. Air Force medical facilities in Southeast Asia were authorized to arrange direct aeromedical evacuation for drug dependent individuals to VA hospitals, irrespective of the member's desires.[66]

(U) Initial results indicated that the rehabilitation program was generally quite successful. However, since one of the major concerns in drug abuse is the psychological addiction which is often precipitated by underlying psychopathology, it would be somewhat premature at the time of this writing to assess the Follow-on Support (Phase V) aspect, due to a paucity of conclusive evidence available in this area.

(U) Further evaluation comments are reserved for Chapter IV, which presents conclusions and recommendations.

CHAPTER IV

CONCLUSIONS

(U) There was a gradual but steady decrease in drug abuse among US servicemen in Southeast Asia, even though statistics indicated an increase in the identification and participation in the drug rehabilitation program. Consistent with this finding was the consensual opinion of professionals[67] involved in the drug abuse program that the Air Force drug abuse control in Southeast Asia was making continual progress. Inherent in the success of this program was the constant effort and willingness to be introspective, to disclose the discrepancies therein, and to implement corrective action supplemented by constructive, innovative ideas and processes. Examples of such improvements were:

(1) Focusing the urinalysis testing program on the 26 years or less age group which increased the rate of drug abuse identification by urinalysis testing.

(2) Education programs which made supervisors and commanders more alert to the early signs of drug abuse,

(3) The requirement for personnel who were identified through apprehension or investigation for drug abuse to be entered into the rehabilitation program,

(4) The increased capability of Social Actions personnel to work closely with other staff agencies to insure all identified drug abusers were entered into rehabilitation,

(5) The implementation of personnel data system codes which facilitated tracking and report of drug abusers, and

(6) Increased customs supervision, suppression, and anti-smuggling activities which identified a greater number of abusers.

(U) It would, then, indeed be incongruous for this report to not disclose the areas in which improvement was needed and where problems were apparent. Additionally, drug program professionals, as well as drug abusers, contributed to the effort of increasing the efficiency and effectiveness of the program. It is with this premise in mind, that the several following statements are included.

(U) Social Actions personnel themselves strongly indicated the necessity for a careful evaluation of the training, expertise, and desire of the personnel assigned in the Social Actions career field. They emphasized as well that critical reevaluation was also required to insure that the credibility of Social Actions personnel was maintained at a high level. These people must be highly motivated, dedicated, and sensitive to the needs and feelings of people in need. In interviews conducted with many drug abusers, the difference between the success and failure of each drug abuser was often largely determined by the attitudes of supervisory people he contacted within the drug program.

(U) Prevention is always an important item and is the best form of treatment. The drug education program was very successful. However, a continuing review of drug education requirements is also critical to its future success. For example, better psychiatric care and consideration of underlying psychological problems of the potential drug abuser might often prevent drug abuse. At the time of this report's preparation, the psychiatric care in Thailand was poor: there was only one psychiatrist and

one clinical psychologist available to meet the needs of all Air Force personnel in Thailand. Considering that drug abuse is only one area that requires psychiatric care, it is all too obvious that there was an appalling lack of treatment available in this area. Furthermore, the drug education programs needed more standardization, and better communication was needed within each command and between commands, especially where mandatory requirements were involved. Some airmen accrued many hours of drug education while some received no drug education.

(U) Better military-civilian liaison and communication would have also greatly facilitated the drug abuse control. Often the military was unaware of very important drug trafficking information that the civilian counterpart had in his possession, and conversely, the military could have released much more helpful information regarding detection, apprehension, and other drug abuse information to civilian authorities.

(U) Another critical concern was the relationship between the squadron and the drug abuse control people. A common complaint was a breach of confidentiality between drug abusers and squadron supervisors. Many times everyone in the shop knew of a command directed Golden Flow when the only individual that should have known was the man to be tested. Other command directed violations occurred such as a supervisor actually making the command directed decision rather than the commander. Also there was a very unsatisfactory execution of the urinalysis testing such as early notification, which provided drug abusers ample time to prepare for a successful urine test, or in other cases, extremely late notification in which case the testee was barely able to arrange an appearance without being delinquent.

Also, considerable harassment within the squadron both by supervisors and peers was noted. In many cases a very negative rapport was created between the squadron, the drug abuser, and Social Actions personnel. It was suggested that work shops, to be attended by Social Actions personnel and key squadron personnel, be periodically directed so that these people might share necessary information on new policies, policy changes, and how these changes might be implemented locally. There was definitely a need to build a stronger, more positive line of communication between the professionals in the drug program and the squadron personnel.

(U) Finally, the local base rehabilitation program should be monitored and reviewed more closely. Some rehabilitation programs were well executed. Others looked good on paper, but in actual practice did little to monitor the drug abuser and provide professional guidance and direction. More than a few drug abusers were sent to a Special Treatment Center when the problem might very well have been resolved at base level with competent, efficient, rehab people.

(U) Summarily, the drug abuse control program made significant strides toward alleviating a very critical problem in the armed forces in SEA. However, as the drug abuser continues to become less of a problem, apathy or complacency about this problem could certainly cause a rapid and damaging reversal. It is therefore critically important that adequate command support be provided the professionals within this program that they might continue to effect a much needed service in an efficient and effective manner.

APPENDIX -- DRUG ABUSE STATISTICS *

DOD Statistics

Service Statistics -- Thailand

* Source of Tables is JUSMAGTHAI (J-1, Personnel) Drug Abuse Control Officer

TABLE 1

CUMULATIVE URINE TESTING RESULTS BY SERVICE (WORLDWIDE)

Cumulative: 17 Jun 71 - 30 Apr 73

		CLINICALLY CONFIRMED POSITIVES	
	NUMBER SCREENED	NUMBER	PERCENT
Army	2,307,623	48,947	2.1
Navy	546,916	3,300	0.6
Marine Corps	161,272	1,357	0.8
Air Force	727,758	2,843	0.4
TOTAL:	3,743,569	56,447	1.5

TABLE 2

YEARLY USAF URINE TESTS AND INVESTIGATIONS (WORLDWIDE)

URINE TESTS	1971	1972	1973
Samples	103,775	336,557	201,166
Positives	483	1,412	705
Percent (%)	.42	.41	.35

INVESTIGATIONS	1971	1972	1973
Investigations	5,825	5,035	2,628
Narcotics	13%	6%	4%
Dangerous Drugs	23%	8%	5%
Marijuana	63%	63%	74%
Multi	-	23%	16%

TABLE 3

DOD THAILAND -- ANALYSIS OF RANDOM SAMPLE URINALYSIS PROGRAM, 1973

	NUMBER TESTED	LAB+	%	LEGAL USE	%	URINARY SURVEILLANCE	%	CLINICAL CONFIRMED	%
Jan									
AF	1,094	39		8		27		4	
USN/CG	17	0		-		--		-	
MAR	430	56						52	
AR	950	42		30		0		12	
	2,491	137	5.1	38	1.5	27	1.1	68	2.7
Feb									
AF	723	23		2		12		9	
USN/CG	53	2		0		2		0	
MAR	366	42						40	
AR	748	25		14		0		11	
	1,890	92	4.9	16	.8	14	.7	60	3.2
Mar									
AF	3,381	85		33		26		26	
USN/CG	69	1				1			
MAR	429	43						40	
AR	1,170	24	3.0	11		0		13	
	5,049	153		44	.9	27	.5	79	1.6

	NUMBER TESTED	LAB+	%	LEGAL USE	%	URINARY SURVEILLANCE	%	CLINICAL CONFIRMED	%
Apr									
AF	3,633	107		42		49		16	
USN/CG	55	1						1	
MAR	482	20						20	
AR	979	28		19				9	
	5,149	156	3.0	61	1.2	49	.9	46	.9
May									
AF	3,385	117	-	35		67		14	
USN/CG	12	-		-		-		-	
MAR	1,419	79						74	
AR	1,026	36		21		0		15	
	5,842	232	4.0	56	.9	67	1.1	103	1.8
Jun									
AF	4,381	101		29		58		14	
USN/CG	50	3				2		1	
MAR	1,385	105						100	
AR	854	30		19				11	
	6,710	239	3.6	48	.7	60	.9	116	1.7

	NUMBER TESTED	LAB+	%	LEGAL USE	%	URINARY SURVEILLANCE	%	CLINICAL CONFIRMED	%
Jul									
AF	3,836	108		38		45		24	
USN/CG	0								
MAR	-	-	-	-	-	-	-	-	-
AR	979	28		16		0		12	
	4,815	136	2.8	54	1.6	45	.9	36	.7
Aug									
AF	3,856	82		39		32		17	
USN/CG	84	4	-	0	-	1	-	3	-
MAR	436	34	-	-	-	-	-	34	-
AR	1,027	14		10		0		4	
	5,403	134	2.5	49	.9	33	.3	58	1.4

TABLE 4

AIR FORCE -- RANDOM SAMPLE URINALYSIS PROGRAM, THAILAND, 1973

	NUMBER TESTED	LAB+	%	LEGAL USE	%	URINARY SURVEILLANCE	%	CLINICAL CONFIRMED	%
Jan	1,094	39	3.6	8	.7	27	2.5	4	.4
Feb	723	23	3.2	2	.3	12	1.7	9	1.2
Mar	3,381	85	2.5	33	.7	26	.8	26	.8
Apr	3,633	107	2.9	42	1.2	49	1.3	16	.4
May	3,385	117	3.5	35	1.0	68	2.0	14	.4
Jun	4,381	101	2.3	28	.6	59	1.3	14	.6
Jul	3,836	108	2.8	38	1.0	45	1.2	25	.5
Aug	3,856	92	2.4	39	1.0	32	.8	21	.5
Sep	3,441	74	2.2	23	.7	47	1.4	4	.1
Oct	3,603	93	2.6	36	1.0	43	1.2	14	.4

TABLE 5a

TAHKLI -- ANALYSIS OF RANDOM SAMPLE URINALYSIS PROGRAM, 1973

	NUMBER TESTED	LAB+	%	LEGAL USE	%	URINARY SURVEILLANCE	%	CLINICAL CONFIRMED	%
Jan	50	4	8.0	0	-	4	8.0	0	-
Feb	28	0	-	-	-	-	-	-	-
Mar	167	5	3.0	2	1.2	2	1.2	1	.6
Apr	217	12	5.5	4	1.8	8	3.7	-	-
May	164	8	4.9	0	-	7	4.3	1	.6
Jun	208	14	6.7	4	1.9	4	1.9	6	2.9
Jul	326	10	3.1	0	-	0	-	10	3.1
Aug	325	14	4.3	1	.3	8	2.5	5	1.5
Sep	253	7	2.8	0	-	6	2.4	1	.4
Oct	480	15	3.1	3	.6	10	2.1	2	.4

TABLE 5b

UBON -- ANALYSIS OF RANDOM SAMPLE URINALYSIS PROGRAM, 1973

	NUMBER TESTED	LAB+	%	LEGAL USE	%	URINARY SURVEILLANCE	%	CLINICAL CONFIRMED	%
Jan	190	4	2.1	0	-	4	2.1	0	-
Feb	176	3	1.7	2	1.1	0	-	1	.6
Mar	589	15	2.5	11	1.9	4	.7	0	-
Apr	741	26	3.5	17	2.3	9	1.2	0	-
May	771	35	4.5	11	1.4	22	2.9	2	.3
Jun	643	24	3.7	10	1.6	14	2.2	0	-
Jul	719	30	4.2	14	1.9	16	2.2	0	-
Aug	761	30	3.9	29	3.8	-	-	1	.1
Sep	634	22	3.5	10	1.6	10	1.6	2	.3
Oct	537	30	5.6	14	2.6	13	2.4	3	.6

TABLE 5c

U-TAPAO -- ANALYSIS OF RANDOM SAMPLE URINALYSIS PROGRAM, 1973

	NUMBER TESTED	LAB+	%	LEGAL USE	%	URINARY SURVEILLANCE	%	CLINICAL CONFIRMED	%
Jan	526	16	3.0	8	1.5	4	.8	4	.8
Feb	194	10	5.1	0	-	6	3.1	4	2.1
Mar	682	24	3.5	8	1.1	0	-	16	2.3
Apr	892	30	3.4	11	1.2	5	.5	14	1.6
May	771	35	4.5	11	1.4	22	2.8	2	.3
Jun	835	20	2.4	3	.3	14	1.7	3	.4
Jul	558	15	2.7	4	.7	0	-	11	2.0
Aug	893	17	1.9	2	.2	0	-	15	.7
Sep	818	4	.5	0	0	4	.5	0	0
Oct	743	1	.1	0	0	0	0	1	.1

TABLE 5d

KORAT -- ANALYSIS OF RANDOM SAMPLE URINALYSIS PROGRAM, 1973

	NUMBER TESTED	LAB+	%	LEGAL USE	%	URINARY SURVEILLANCE	%	CLINICAL CONFIRMED	%
Jan	208	15	7.2	-	-	15	7.2	-	-
Feb	145	8	5.5	-	-	5	3.4	3	2.1
Mar	495	20	4.0	6	1.2	11	2.2	3	.6
Apr	621	15	2.4	3	.5	10	1.6	2	.3
May	405	18	4.4	4	1.0	5	1.2	9	2.2
Jun	843	18	2.1	3	.4	11	1.3	4	.5
Jul	726	13	1.8	4	.5	6	.8	2	.3
Aug	303	12	3.9	1	.3	11	3.6	0	-
Sep	535	14	2.6	4	.7	10	1.8	0	-
Oct	587	14	2.4	6	1.0	8	1.4	0	0

TABLE 5e

NKP -- ANALYSIS OF RANDOM SAMPLE URINALYSIS PROGRAM, 1973

	NUMBER TESTED	LAB+	%	LEGAL USE	%	URINARY SURVEILLANCE	%	CLINICAL CONFIRMED	%
Jan	120	0	-	-	-	-	-	-	-
Feb	180	2	1.1	-	-	1	.6	1	.6
Mar	370	8	2.2	3	-	5	1.4	0	-
Apr	357	11	3.1	4	.8	7	2.0	0	-
May	353	12	3.4	6	1.1	6	.7	0	-
Jun	390	6	1.5	4	1.7	2	.5	0	-
Jul	250	7	2.8	4	1.0	3	1.2	0	-
Aug	554	5	.9	2	1.6	3	.5	0	-
Sep	386	6	1.6	2	.4	4	1.0	0	-
Oct	385	7	1.8	1	.3	6	1.6	0	-

TABLE 5f

UDORN -- ANALYSIS OF RANDOM SAMPLE URINALYSIS PROGRAM, 1973

	NUMBER TESTED	LAB+	%	LEGAL USE	%	URINARY SURVEILLANCE	%	CLINICAL CONFIRMED	%
Jan	-	-	-	-	-	-	-	-	-
Feb	-	-	-	-	-	-	-	-	-
Mar	1,078	13	1.2	3	.3	4	.4	6	.6
Apr	805	13	1.6	3	.4	10	1.2	0	-
May	921	9	1.0	3	.3	6	.7	0	-
Jun	1,462	19	1.3	4	.3	14	1.0	1	.6
Jul	1,257	33	2.6	12	.9	20	1.6	1	.7
Aug	1,020	14	1.4	4	.4	10	1.0	0	-
Sep	815	21	2.6	7	.9	13	1.6	1	.1
Oct	871	26	3.0	12	1.4	12	1.4	2	.2

TABLE 5q

SUPTHAI -- ANALYSIS OF RANDOM SAMPLE URINALYSIS PROGRAM, 1973

	NUMBER TESTED	LAB+	%	LEGAL USE	%	CLINICAL CONFIRMED	%
Jan	950	42	4.4	30	3.2	12	1.3
Feb	748	25	3.3	14	1.9	11	1.5
Mar	1,170	24	2.1	11	.9	13	1.1
Apr	979	28	2.9	19	1.9	9	.9
May	1,026	36	3.5	21	2.0	15	1.5
Jun	854	30	3.5	19	2.2	11	1.3
Jul	979	28	2.9	16	1.6	12	1.2
Aug	1,027	14	1.4	10	1.0	4	.4
Sep	818	24	2.8	14	0	10	1.2
Oct	849	41	4.8	12	1.4	29	3.4

TABLE 5h

MARINES -- ANALYSIS OF RANDOM SAMPLE URINALYSIS PROGRAM, 1973

	NUMBER TESTED	LAB+	%	CLINICAL CONFIRMED	%	URINARY SURVEILLANCE	%
Jan	430	56	13	52	12	-	-
Feb	366	42	11	40	11	-	-
Mar	429	43	10	40	9	-	-
Apr	482	20	4	20	4	-	-
May	1,419	79	6	74	5	-	-
Jun	1,385	105	8	100	7	-	-
Jul	-	-	-	-	-	-	-
Aug	436	34	8	34	8	-	-
Sep	DEPARTED						

TABLE 5i

USN/CG -- ANALYSIS OF RANDOM SAMPLE URINALYSIS PROGRAM, 1973

	NUMBER TESTED	LAB+	%	LEGAL USE	%	URINARY SURVEILLANCE	%	CLINICAL CONFIRMED	%
Jan	17	0	-	-	-	-	-	0	-
Feb	53	2	-	0	-	2	-	0	-
Mar	69	1	3.8	-	-	1	3.8	0	-
Apr	55	1	1.4	-	-	-	-	1	1.8
May	12	0	0	-	-	-	-	-	-
Jun	90	3	3.3	-	-	1	1.1	2	2.2
Jul	0	-	-	-	-	-	-	-	-
Aug	84	4	-	0	0	1	1.2	3	3.6
Sep	0	-	-	-	-	-	-	-	-
Oct	164	3	1.8	1	.6	-	-	2	1.2

FOOTNOTES

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GLOSSARY OF ACRONYMS

AB	Air Base
AFR	Air Force Regulation
AFRTS	Armed Forces Radio and Television Service
AFVN	Armed Forces Vietnam Network
BNDD	Bureau of Narcotics and Dangerous Drugs
CHECO	Contemporary Historical Examination of Current Operations
DEFT	Drug Education Field Team
DEROS	Date Eligible (Effective) for Return From Overseas
FRAT	Free Radical Assay Technique
GLC	Gas Liquid Chromotography
JUSMAG	Joint United States Military Advisory Group
LPCP	Limited Privileged Communications Program
LSD	Lysergic Acid Diethylamide
MACTHAI	Military Assistance Command, Thailand
MACV	Military Assistance Command, Vietnam
OSI	Office of Special Investigations
PACAF	Pacific Air Forces
PACAFM	Pacific Air Forces Manual
R&R	Rest and Recuperation
RTAFB	Royal Thai Air Force Base
RTG	Royal Thai Government
RVN	Republic of Vietnam
SEA	Southeast Asia

SIR	Serious Incident Report
SNO	Special Narcotics Organization
STP	Demethoxy-Amphetamine
TDY	Temporary Duty
TLC	Thin Layer Chromotography

GLOSSARY OF PSYCHOLOGICAL TERMS

Anxiety	A painful psychological reaction to threat.
Dyssocial	Refers to the socially maladjusted personality who follows a criminal pursuit.
Etiology	The study of causes or origins of a disease.
Manic depressive	An effective psychosis characterized by severe and inappropriate mood swings.
Mentally undifferentiated infant	Early stage of nervous system development when little cognition occurs and the basic needs and drives are biological.
Narcissism	Self love.
Nosology	Refers to a classification of mental disease by the American Psychiatric Association.
Passive dependent	A personality characterized by passivity and dependency.
Passive inadequacy	An attitude of submissiveness and inferiority.
Passive receptive	A sensation characterized by passivity and total submissiveness.
Pathological Personality	Refers to a maladjusted personality.
Pharmacological	An effect of drugs on living organisms.
Premorbid personality	The personality prior to the probable onset of mental illness.
Psychoneurosis	Mental illness characterized primarily by anxiety and an awareness of disturbed mental functioning.
Psychotic	Individual whose mental functioning is severely impaired and interferes grossly with his capacity to meet ordinary demands of life.
Sociopathic	Referring to a socially maladjusted personality characterized by a lack of morals or guilt.